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Virginia MEDICAL MONTHLY

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June 1946

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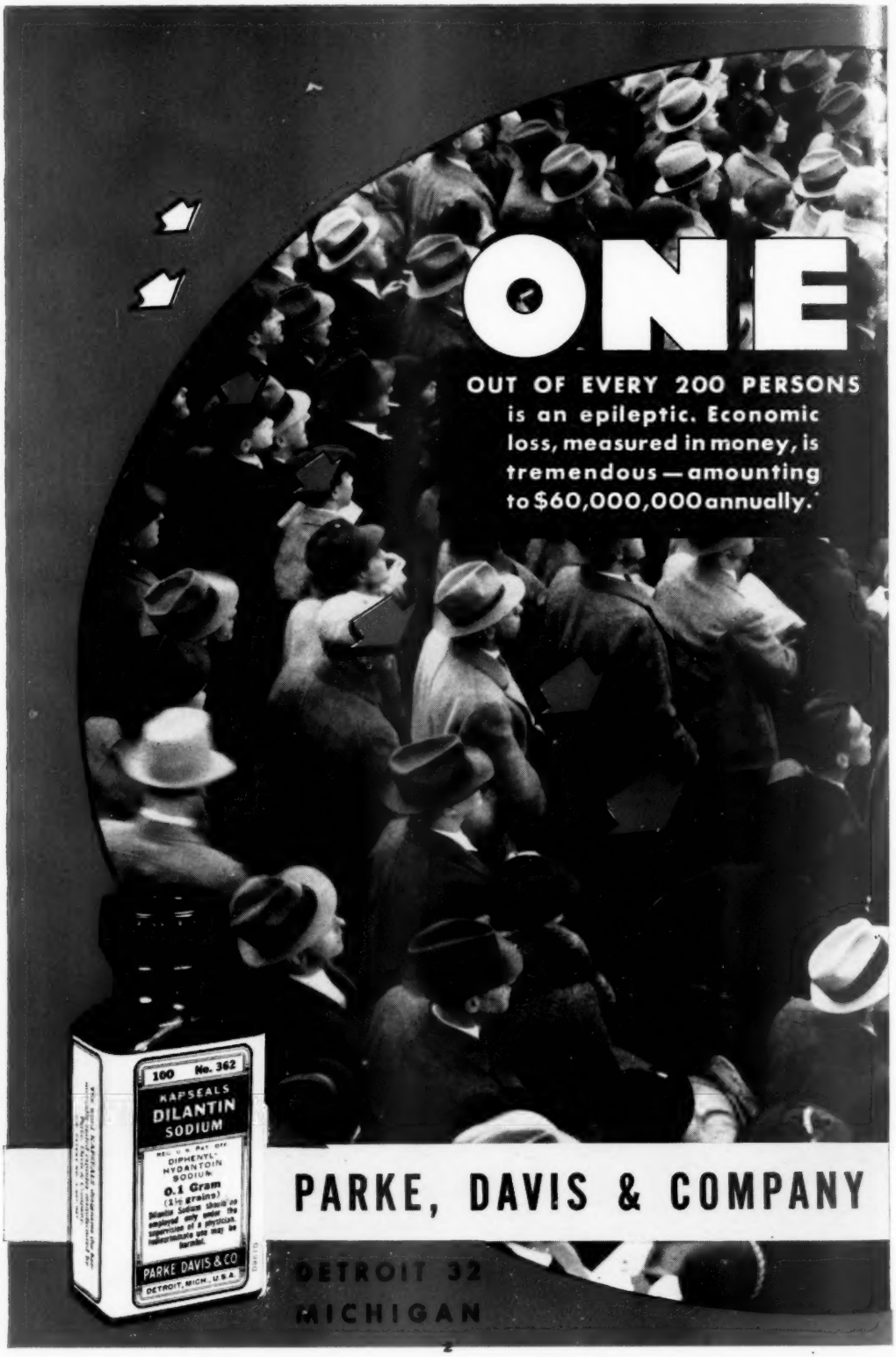

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GUEST EDITORIAL

Transthoracic Vagotomy for Peptic Ulcer

THE cause of ulcer of the duodenum or stomach is not yet thoroughly understood and treatment is not yet entirely satisfactory. Recent clinical developments are therefore of interest to the physician who treats ulcer patients. It is known that two important mechanisms regulate gastric secretion and motility, and may influence the development and the persistence of peptic ulcer. One is hormonal or chemical and is usually activated by the presence of food in the stomach or duodenum. The other is nervous and responds to stimuli of a neurogenic, psychogenic, or reflex nature.

New treatments that affect the chemical mechanism have been reported. Co Tui and his associates have used a protein hydrolysate diet. Ivy has studied the effect of enterogastrone which inhibits the chemical mechanism. McElin and Horton have employed an antihistamine preparation, Benadryl. Certain patients are refractory to medical treatment and require subtotal gastric resection. This procedure interrupts the chemical mechanism by removing the antrum of the stomach and excluding the duodenum. Although gastric resection has proved an effective treatment for many patients it may be associated with poor nutrition and occasionally with the development of a stoma ulcer.

Surgical treatment has recently been directed at the nervous mechanism that regulates gastric secretion and motility. The visceral afferent and efferent fibers of the vagus are known to play an essential role in this neural regulation. Dr. Dragstedt and his associates in 1943 introduced transthoracic supradiaphragmatic resection of the lower portion of the two vagus nerves and their branches about the lower esophagus as a substitute for gastric resection. He has used this relatively simple operation in more than seventy patients. There are twenty-seven additional cases in our series.

Preliminary observations of the effect of vagotomy have been encouraging. The patients are exceptionally well-pleased, eat normal diets, are relieved of symptoms of ulcer, and gain weight. All ulcers have evidently healed and as yet there is no evidence of recurrence. Physiological studies have demonstrated that the motility of the fasting stomach is markedly decreased. The volume and the acidity of the secretions of the fasting stomach are also decreased. The immediate relief of pain after vagotomy may be related to decrease of motility or spasm, decrease of acidity, or possibly to interruption of some pain pathways from the stomach. In three patients with partial obstruction at the ulcer site the decrease of motility has necessitated Finney pyloroplasty or gastro-jejunostomy. Vagotomy is at the present time an experimental procedure. Early observations, however, indicate that the operation yields gratifying results even in patients with intractable pain, stoma ulcer, or recurrent hemorrhages.

Since vagotomy should block the neurogenic, psychogenic, or reflex gastric secretory mechanism and should leave the chemical or hormonal mechanism intact, the results of vagotomy seem to indicate that these neurogenic factors should receive careful consideration in either medical or surgical treatment.

KEITH S. GRIMSON.*

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DELAYED TONSILLAR HEMORRHAGE*

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Among the potential complications of tonsillectomy, few cause as much concern as secondary bleeding, a condition which interferes with a smooth convalescence and may be even dangerous. We have never observed such hemorrhages later than on the eleventh post-operative day and usually they occur from the fifth to the tenth day after surgery. This is the time when starvation and excessive granulations might be expected to aggravate any factors favoring bleeding.

It is difficult to obtain an accurate picture of the frequency of delayed bleeding encountered by the individual surgeons. Inquiries concerning the incidence of secondary hemorrhage have occasioned statements ranging from "extremely rare" to a frequency of 10 per cent. Accurate figures are often not available because patients bleeding only slightly may call the general practitioner without the surgeon's even knowing of the complication. Again, the operator may treat a patient in his office and no hospital record is kept of the incident.

CASE MATERIAL

The present paper deals with 1808 patients subjected to tonsillectomy during the period 1939 to 1944, inclusive. It has been our practice to instruct every patient to report to the hospital in case of bleeding. Therefore, the observations presented should reflect the true situation, except for those few patients who bled but, disregarding our instructions, did not report to us.

One hundred and eight hemorrhages (5.97 per cent) were encountered in the whole series. Of these 25 occurred within 24 hours after surgery and 83 were delayed. Thus, this latter variety constituted about 76.8 per cent of all the bleedings encountered. Primary hemorrhages, which are probably due to imperfect hemostasis at the time of operation, are not considered here. Table I shows the number of operations performed and the incidence of delayed hemorrhage in each year.

*Read before the Virginia Ophthalmological and Otolaryngological Society, April 28, 1945.

TABLE I.

Year	Number of T & A	Number of delayed hemorrhages	Per cent of delayed hemorrhages
1939	284	13	4.57
1940	256	11	4.29
1941	226	16	7.07
1942	303	19	6.27
1943	354	16	4.52
1944	385	8	2.08

Incidence of delayed hemorrhages encountered after tonsillar operations in years 1939-1944.

Naturally, such a high incidence of secondary hemorrhage as encountered by us before 1944 presented a challenge to investigate the etiology of this complication and to lower its occurrence.

CAUSES OF DELAYED HEMORRHAGES

General Considerations.—Late tonsillar bleeding has been ascribed to numerous causes, such as: hepatic disease; blood dyscrasia; syphilis; malnutrition; vitamin C deficiency; excessive trauma; premature sloughing of the covering membrane resulting in capillary oozing; infections; and administration of certain drugs.

Undoubtedly these are all contributing factors. As to their relative importance, however, opinions are divided. For instance, some workers believe that infection of the tonsillar fossae is an all-important etiologic factor. If this were so, then the highest percentage of bleeding should be encountered during those months of the year in which pneumococci, staphylococci, and hemolytic streptococci are prevalent in cultures from patients with acute or chronic naso-pharyngeal infections. With this in mind, all such cultures studied in the Rockingham Memorial Hospital Laboratory during a four-year period were reviewed. As had been expected, there was a higher incidence of positive cultures in November, December, January, February, and March as compared with those of June, July, August, and September. With the object of correlating these findings with the occurrence of late hemorrhage encountered during the same groups of months in the period from 1939 to 1943, inclusive, the annual figures of Table I were broken down to monthly figures (Chart I).

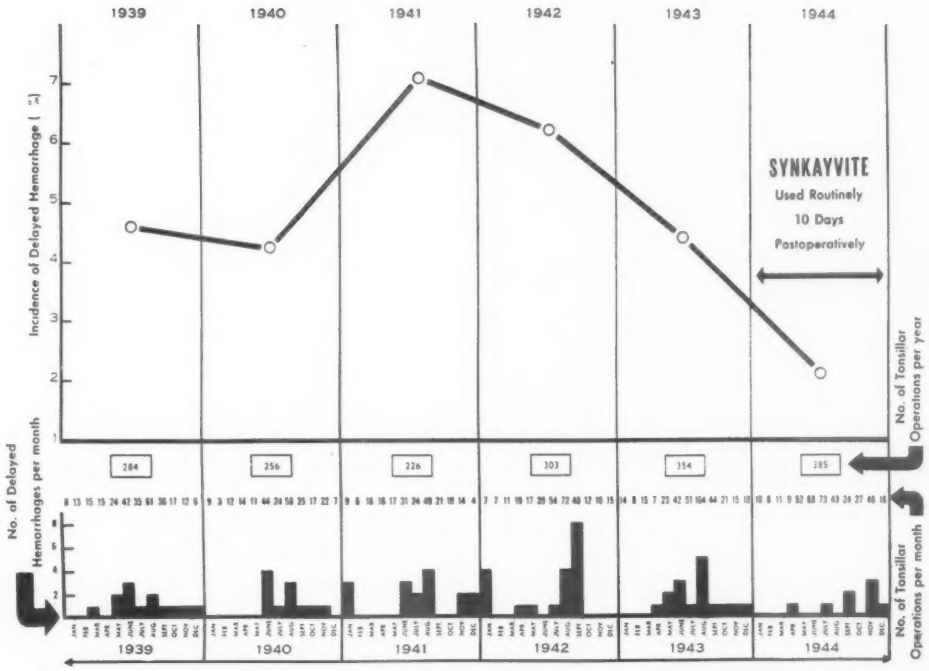


Chart 1. Graphic analysis of tonsillar operations during the period 1939-1944, showing incidence of delayed hemorrhages.

Calculated on a percentage basis, it appears that in the winter months, characterized by a higher incidence of infection, the frequency of hemorrhage (namely, 6.3 per cent) is higher than during the summer months (5.3 per cent). However, this difference is not sufficiently significant to look upon infection, although unquestionably favoring hemorrhage, as an all-important factor in its causation.

The opinion was voiced by some that a seasonal factor is of paramount importance in the causation of late bleeding. They claim that hemorrhages are prone to occur during the hot months of the year. Our figures show that heat is no more the all-important factor than infection, although we feel that high temperatures are a contributing factor. The work by Mills and his associates[1] lends credence to this supposition. These investigators observed that hemorrhagic states rarely developed in rats kept at moderately cool temperatures. In tropical heat, however, especially older animals were prone to severe hemorrhages when fed on a vitamin K-free diet. Addition of vitamin K prevented hemorrhagic states but the requirement of the antihemorrhagic vitamin per gram of food was found to be twice as high for rats in a hot environment as for those in a cold one. Clotting tests revealed that the delay was more marked among the former animals than among the latter. The above authors suggest that the heat may interfere with the production of vitamin K by intestinal bacteria. Furthermore, they suspect that a higher prevalence of vitamin K deficiency among residents of tropical climates may account for the four times greater incidence of hemorrhagic disease among infants born in the Gulf States than among those born in the north. If this suspicion is warranted, it is also possible that vitamin K deficiency is more frequent clinically during the hot season than the rest of the year. An adequate supply of this vitamin is necessary for production of prothrombin, essential for normal blood clotting. Consequently, a state of hypoprothrombinemia may develop more readily during the summer months and this may account for a considerable incidence of delayed tonsillar hemorrhage in the hot season.

Drug-Induced Prothrombinopenia.—In connection with the foregoing, the prothrombin-lowering effect of the salicylates, already demonstrated by several investigators, must be considered. Link[2] and his coworkers produced hypoprothrombinemia by feeding

salicylates to rats kept on a vitamin K deficient diet. Many of the animals died with hemorrhagic manifestations. Administration of vitamin K had a protective effect against the salicylate action. Soon clinicians[3,4,5] took up the work and proved that therapeutic doses of salicylates induced prothrombinopenia in healthy subjects and in rheumatic fever patients. Furthermore, vitamin K was shown to counteract, also in humans, the salicylate effect on prothrombin. Recently Fashena and Walker[6] reported a case of rheumatic fever in which medication with salicylates prolonged the prothrombin time to 2 minutes 45 seconds—"a value more than five times the normal, which connotes almost complete absence of circulating prothrombin". In this instance a daily dose of 8 gm. of sodium salicylate had been given for several days. Although such high doses are not administered in tonsillar cases, the amounts utilized for post-operative pain-relief may result in a hypoprothrombinemic state. Such salicylate-induced prothrombin deficiency may become pronounced during the hot season when there is tendency to avitaminosis K.

Neivert,[7] working with Pirk and Engelberg, investigated the prothrombin effect of aspirin alone and in combination with Synkayvite, the Roche vitamin K-like compound, in healthy subjects. Oral administration of 40 gr. (2.6 gm.) acetylsalicylic acid a day in divided doses resulted in a significant prothrombin deficiency. In some cases the hypoprothrombinemia became evident after but one day of salicylate medication, while in others a longer period was required. Concurrent vitamin K administration afforded full protection against the salicylate-induced prothrombinopenia. Furthermore, Neivert studied prothrombin levels in tonsillar cases preoperatively and post-operatively. There was a significant decrease of prothrombin five to seven days post-operatively in those patients who had been given aspirin alone. In a second group the salicylate was given in combination with Synkayvite (either in form of suppositories or tablets) with 5 mg. of the vitamin K preparation added to each 5 gr. of aspirin. The patients of this group, on re-examination five to seven days post-operatively, showed either no decrease of prothrombin at all, or at the most, a reduction which could not interfere with normal clotting.

LABORATORY EXPERIMENTS

In an attempt to corroborate these findings, we carried out prothrombin estimations in 20 healthy individuals before and after salicylate medication. In the beginning, we used the Page method,[8] a very intricate procedure, which in our hands was difficult to control. We then switched to the technique devised by Quick,[9] utilizing first whole, and later diluted, plasma.

Few of our cases showed such marked and continued salicylate-induced hypoprothrombinemia as that observed by Neivert. Notwithstanding this, the accuracy of his findings is not disputed. It is realized that the difficulties encountered in performing prothrombin assays according to Page's method are largely responsible for our failure to demonstrate the prothrombin lowering effect of salicylate in all subjects studied.

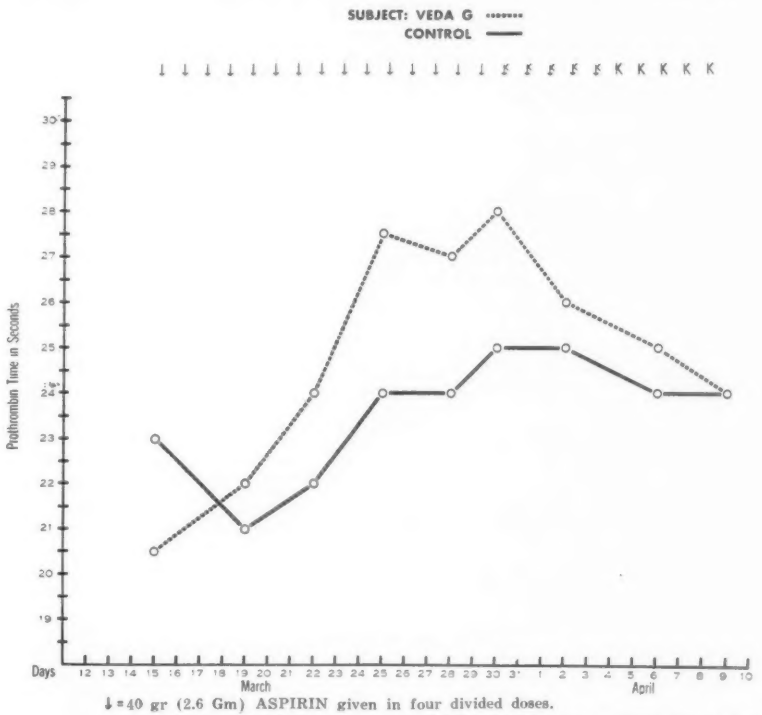
Of those who responded significantly the findings in a student nurse are here presented. Miss Veda G., with a prothrombin time of 20.5 seconds (determined by Quick's method in diluted plasma), was given 40 gr. of aspirin a day in divided doses for 15 days. There was a continuous rise of the prothrombin time, reflecting a decrease of prothrombin activity. When the prothrombin time was prolonged to 28 seconds, experimental tablets, each containing 5 gr. of acetyl-salicylic acid and 5 mg. of Synkayvite were substituted for aspirin and given for five more days. The prothrombin time dropped promptly and continued to do so when Synkayvite alone was given. The accompanying Chart 2 illustrates the procedure, the dosage employed, and the results obtained in this subject, and in a control. As evidenced by these results and by similar findings in other subjects, the addition of Synkayvite to aspirin affords protection against salicylate-induced prothrombinopenia.

CLINICAL STUDY

We have been considering for some time the possibility that a vitamin K deficiency is an important factor in the causation of late tonsillar hemorrhage. With Link's discovery of a prothrombinopenic effect of salicylic acid in rats and with the duplication of his findings by other investigators in humans, the routine administration of vitamin K to tonsillar patients seemed a logical step. Consequently, since the beginning of 1944 each of our patients received

a prescription for Synkayvite tablets. Adults were instructed to take two of these (10 mg.) a.c. and h.s. for ten days post-operatively. Children were given only 5 mg. per dose. In addition, patients were advised to take aspirin, before meals, sparingly according to need. The single dose in adults was 5 gr. and in children 2½ gr.

In a small series of patients, tablets containing a combination of aspirin and vitamin K were employed. With nursing care at a premium, these administration had no part in the post-operative routine. The incidence of delayed hemorrhages then ranged from 4.29 per cent to 7.07 per cent. In relation to the incidence of bleeding in the years 1939, 1940, and 1943, this is a decrease of about 50 per cent. If compared with our findings in 1941 and 1942, the decrease is even 70 per cent and 66 per cent respectively. The upper part of Chart I demonstrates graphically the reduced incidence of hemorrhage in 1944, when adequate doses of Syn-



↓ = 40 gr (2.6 Gm) ASPIRIN given in four divided doses.
ℰ = 40 gr (2.6 Gm) ASPIRIN + 40 mg. SYNKAYVITE given in four divided doses.
K = 40 mg SYNKAYVITE given in four divided doses.

Chart 2. Curves of prothrombin time recorded for subject Veda G. and a control after oral administration to the former of acetyl salicylic acid, after acetyl salicylic acid-Synkayvite medication, and after administration of Synkayvite.

proved practical and useful in the hospital routine. However, patients rarely need an analgesic for full ten days after a tonsillectomy. On the other hand, vitamin K should be given until the danger of hemorrhage is passed. Therefore, we returned to separate administration of the antihemorrhagic vitamin and the analgesic as outlined above.

Under this regimen, there were eight late hemorrhages in a series of 385 cases, an incidence of 2.08 per cent. This compares very favorably with our findings of the five previous years when vitamin K kayvite were given. Of the patients who bled, one required a suture; in one hemostasis was accomplished by application of an astringent and in the remaining six sedation and bed rest were the only measures necessary. It was obvious that the few episodes of hemorrhage occurring in the 1944 series were of less consequence and required less surgery than those encountered during previous years when vitamin K was not administered post-operatively. Then a suture or tie was usually required since attempts at hemostasis by local application of an

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astringent or by injection of a vaso-constrictor around the bleeding point failed in most instances.

SUMMARY AND CONCLUSIONS

Observations on a series of 1,808 patients subjected to tonsillectomy during the years 1939 to 1944 inclusive are presented. In these 108 hemorrhages occurred, of which the great majority (76.8 per cent) were delayed.

Secondary tonsillar bleeding may result from a variety of causes. We cannot ascribe to any one factor exclusive significance. However, infection, salicylate-induced prothrombin deficiency and K-hypovitaminosis are among the most important predisposing factors.

Evidence is presented that in some individuals a daily dose of 40 gr. acetyl-salicylic acid causes a significant prolongation of the prothrombin time after only a few days of medication. In others, it takes longer for the hypoprothrombinemia to develop, depending on the individual's vitamin K reserve and diet. Since prothrombin deficiency interferes with normal blood clotting, salicylates should not be used in any form for post-tonsillectomy analgesia unless given in conjunction with vitamin K in adequate dosage.

The incidence of late tonsillar hemorrhage, ranging in the years 1939 to 1943 inclusive from 4.29 per cent to 7.07 per cent was reduced to 2.08 per cent in 1944 when Synkayvite tablets were administered routinely.

ACKNOWLEDGMENTS

I wish to express my sincere thanks to Dr. W. E. Bray, Director of the University of Virginia Laboratory, who not only graciously supplied thromboplastin, but also checked our prothrombin results on several subjects.

My gratitude goes also to the staff of the Rockingham Memorial Hospital Laboratory, especially to Mrs. Elizabeth Harman, who, in carrying out the many prothrombin tests, gave unstintingly of her time, thus making this work possible. Furthermore, credit must be given to Dr. R. Engelberg, of Presbyterian Hospital, of New York, who imparted her great experience in carrying out Page's technique of prothrombin assays to Mrs. Harman. Dr. Leo A. Pirk, of Hoffmann-La Roche, Inc., Nutley, New Jersey, was very generous with material and his helpful suggestions regarding execution of this study are appreciated.

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CHORIO-EPITHELIOMA WITH HERPES GESTATIONIS REPORT OF A CASE*

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In presenting the case herein described we wish to add another report to the literature on this subject, and to record a group of findings which may add to the already accumulated knowledge of one of the unusual types of malignancy. Chorio-epithelioma is in itself far from common, and herpes gestationis may be considered rare. Here, however, a single case was encountered wherein both of these conditions were present and in which we were able to secure a rather complete study. The time interval, which elapsed between the opening act in its history and the final curtain, covered a period of four years, and the attention of the writers was first attracted not to a malignancy, but rather to what was considered to be a most unusual complication of normal pregnancy. Before going directly into the case we wish to discuss briefly some phases of the two conditions.

The subject of chorio-epithelioma was first referred to in the literature by Gregorini[1] in 1795. He reported a case of malignant degeneration of a hydatidiform mole in which metastatic growths appeared in the lungs following the expulsion of the mole. Sanger[1] in 1888 described the growth, believing it to be a sarcoma arising from the decidua and therefore of maternal origin. Frankel[1] showed its origin in the epithelium of the chorion and considered it a carcinoma. Marchand,[1] however is entitled to the credit of identifying the true histogenesis of the growth. He demonstrated the origin to be in the syncytium and Langhans' layers of the chorion and named it chorio-epithelioma malignum.

Deciduoma malignum may be considered to represent a singular development in malignant teratomata, but the failure to demonstrate teratomatous elements casts doubt upon this theory (Maun and Green[2]). Usually it is found that the process develops subsequent to some form of pregnancy. It may follow normal pregnancy, abortion, ectopic pregnancy or hydatid mole. The last is the most frequent offender, as about 5 per cent of these become malignant. Hertig,[3] of the Boston Lying-In Hospital, in 1940 observed that hydatid degeneration of the chorion is not infrequent. He showed that approximately 50 per cent of all spontaneous abortions are due to defective ova, and more than 60 per cent of these present some hydatid degeneration of their villi. Again, all of us have seen abortions yielding large amounts of placental tissue but without any evidence of foetal form. Hydatid degeneration is common in these placentae. A consideration of the foregoing may perhaps lessen our over-enthusiasm for various methods of preventing spontaneous abortion. Finally, it is to be remembered that malignancy may appear only after a period of many years has elapsed.

The diagnosis of tumors arising from the chorion is most perplexing. Even in normal pregnancy the implantation of the placenta itself is dependent upon invasion of the uterine wall, the trophoblastic tissue penetrating the uterine veins and being deported to distant parts of the body. This is very closely akin to malignancy, and Novak has referred to it as a "Physiologic Metastasis". The presence of metastases, therefore, does not absolutely decide the question of malignancy for the reason that the primary, as well as the secondary growths, may regress and disappear completely. In these cases a correlation of the clinical features, microscopic findings, and laboratory studies is imperative if a correct diagnosis is to be attained.

In regard to the application of the Friedman test, we believe that this procedure is by no means infallible. In this condition the test is strongly positive even when the spinal fluid is used, and frequently a quantitative determination may be made. Mistakes, however, do occur, as two cases of chorio-epithelioma with negative Aschheim-Zondek tests were reported by Tuchschmid[4] in 1943. One of us has seen a total removal of the pelvic viscera performed on a patient, who suddenly developed a positive reaction in the spinal fluid following a previous

*Read before Manchester Medical Society, Richmond, February 5, 1946.

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abortion. After operation, examination failed to show any pathology in the tubes, ovaries, or uterus.

The prognosis is always to be guarded in these cases, as unexpected recoveries may occur. In certain cases the microscopist will be absolutely unable to decide as to the course of events. It is believed that regression rarely if ever occurs in those types with a preponderance of Langhans cells. Removal of the primary growth is imperative. This includes the extirpation of the entire uterus and any secondary growths in the vagina or vulva. Radiation therapy is customarily advised.

The skin eruption in this case is similar to that reported by Elliott[5] in 1938, in association with a chorio-carcinoma secondary to a hydatidiform mole. Inasmuch as the cutaneous manifestations appeared about the time that the malignancy began to grow, and since they became more extensive with increased activity of this malignant growth, he concluded that the skin rash should be classified as herpes gestationis.

Herpes gestationis was first described by Bunel in 1911, and is an uncommon cutaneous complication of pregnancy characterized by a recurrent generalized vesicular eruption associated with severe itching. The etiology of the disease is unknown. Some authors feel that the lesions result from injury to the vasomotor nerves by toxins manufactured by the fetal tissues or by cells of the chorionic epithelium, while other investigators have advanced the theory that renal insufficiency is the cause. Rostenberg[6] reports that the gonadotropin was protracted for several months after parturition in these cases. Weidman[7] observed that the degree of pruritus varied with fluctuations in the gonadotropic principle but Antoine[8] thought that a toxicosis produced by the ovum in association with an unknown virus was causative.

This condition may appear at any time during pregnancy, although it is more common in the latter half, and is more frequent in primiparae between 30 and 35 years of age. The disease may recur in successive pregnancies or return intermittently every second or third pregnancy. There is intense and persistent pruritus in the early stages followed by a generalized herpetiform vesicular rash covering the entire body. Eosinophilia during the acute stage may range as high as 50 per cent. Treatment is non-specific and local applications such as soothing lotions for the relief of itching are helpful until termination of the pregnancy brings about its resolution.

REPORT OF A CASE

Mrs. L. W., age 34, entered the hospital on September 25, 1945, acutely ill and suffering from a diffuse rash which covered the entire body and involved the palms of the hands and the soles of her feet. Morphine had been given for relief of the intense itching and burning. She was vomiting,

Fig. 1

and stated that she had never had a well day since becoming pregnant. Her last menses occurred on April 1, but no movements had been felt. During

Fig. 2

this pregnancy she had suffered with marked nausea and progressive weakness, and had been treated in a hospital in a nearby city for two attacks of vaginal

Fig. 3

bleeding. Each of these responded to rest in bed. On August 5 three vaginal cysts were removed. These were filled with bloody fluid, but microscopic

Fig. 4

examination showed no trace of malignancy. Following her return home she continued to become weaker, nausea increased, and on September 1 she noticed "mosquito bites" on the arms, legs, and abdomen which itched from the start. The rash gradually spread and the discomfort became most distressing. She believed that she had lost 25 pounds since April.

The family history and her past history are both unessential until the birth of her child now ten years of age. Four years ago she aborted accidentally at two and one-half or three months' gestation. It

Fig. 5

is noteworthy that no fetus was seen at this time, and so much bleeding occurred that two curettements were required. Several weeks later she was again curetted by a second surgeon who was purposefully "looking for cancer" but nothing was found.

Examination revealed a white female, emaciated, vomiting, restless, and in pain. Temperature, pulse and respiration were normal and the heart and lungs were negative on physical examination. Over the trunk and extremities there was a generalized symmetrical papulo-vesicular rash with some excoriated and secondarily infected areas. (Figures 1, 2, 3, 4 and 5.) An abdominal mass, apparently the uterus, extended 10 cm. above the symphysis pubis. An-

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Fig. 6

other mass was palpated in the region of the left ovary but this finding was not definite.

Laboratory studies were not unusual except for a white count of 10,500 and hemoglobin of 64 per cent. These figures changed gradually to show an increasing infection and a progressive secondary anemia. On October 3 an eosinophile count of 10 per cent was noted. Blood urea was 34 and the urinary examination showed a mild infection. The Wassermann was negative and she was Type "A", Rh positive. A Friedman test on September 1 was reported positive.

The following day the patient was seen by members of the surgical, obstetrical and dermatological services. In view of the patient's serious condition and the above findings, we felt that a diagnosis of herpes gestationis with missed abortion was justifiable, and it was decided to interrupt pregnancy per vaginam. Accordingly, two catheters were inserted into the uterus on Wednesday, September 26. During the next four days various drugs were used to accelerate the emptying of the uterus but nothing happened. X-ray of the uterus showed two catheters with no suggestion of fetal form.

Until this time all of us believed her to be pregnant, but now it appeared very doubtful and, to decide this beyond any doubt, the cervix was dilated, using a small Voorhees' bag. By this means the operator was able to palpate a mass adherent to the uterine wall which could not be identified, ex-

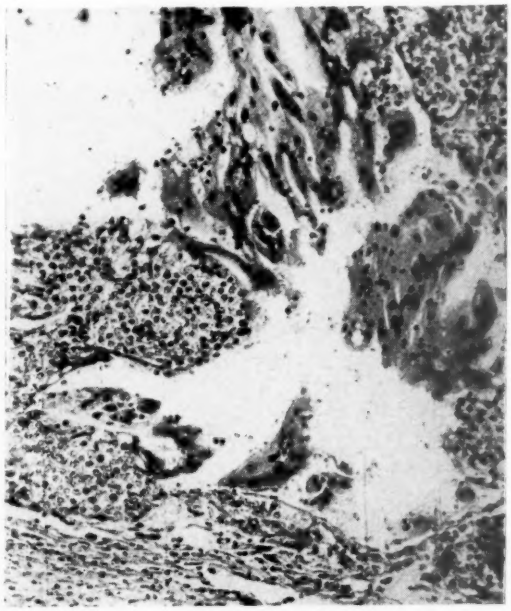

Fig. 7

cept to say that it consisted of degenerated, necrotic, almost bloodless, material. Portions were removed

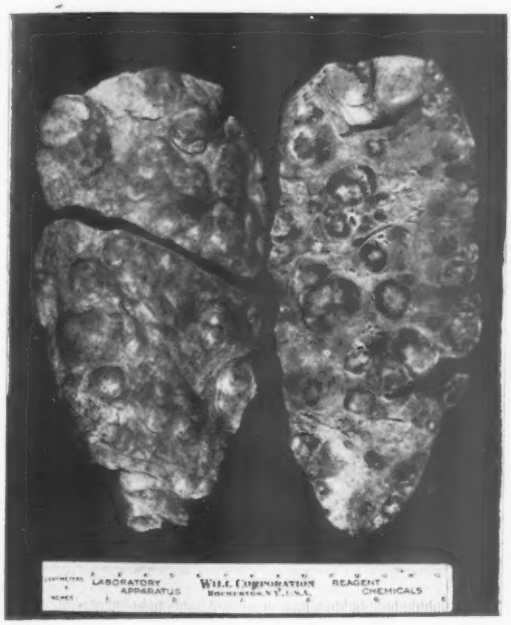

Fig. 8

with the examining fingers and frozen sections made, but no cell structure was found definite enough to determine the nature of the growth.

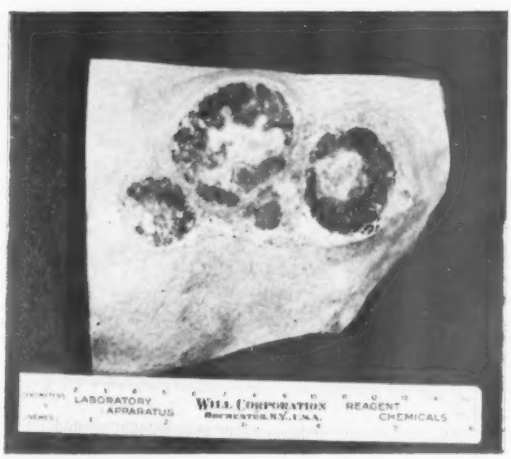

Fig. 9

In view of the above findings we were now clinically sure of a diagnosis of chorio-epithelioma, and it was decided to open her abdomen even though her grave condition and infected skin over the abdomen made this a most serious procedure. The operation consisted of total hysterectomy and bilateral salpingo-oophorectomy. The patient stood the operation well and reacted nicely following two transfusions.

The pathological report showed a tumor mass in the uterus as large as an orange, the uterus itself being enlarged to the size of a four-months' pregnancy. Both ovaries were cystic, the left being greatly enlarged and showing solid masses of chorio-epithelioma. (Figure 6) Microscopic examination

Fig. 10

showed chorio-epithelioma which was later classified by Dr. Broders of the Mayo Clinic as Grade 3 malignancy. (Figure 7) There was no evidence of any metastasis in the abdomen.

Following operation the skin healed completely, and the patient improved for about two weeks. Then she began to cough and expectorate a little blood, and *x*-ray examination on October 15 showed metastatic malignancy filling the lungs. A Friedman test on October 22 was strongly positive. From this time on the patient became rapidly worse and died about one month after operation on November 6.

A post-mortem examination was performed by Dr. Regena Beck and the positive findings are given below.

The *body* is extremely emaciated, the skin appearing deeply tanned and presenting circumscribed areas especially prominent on the arms, legs and

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abdomen. These are the healed lesions of herpes gestationis.

The *lungs* are completely filled with hemorrhagic nodular masses of the growth, the gross picture being that of metastatic chorio-epithelioma. Figure 8)

The *liver* is enormously enlarged, the lower edge coming to within two inches of the iliac spine on the right side. It is now filled with metastatic nodules. (Figures 9 and 10)

The *spleen* has several small metastatic nodules but is comparatively normal in shape, size and color.

The remainder of the post-mortem findings are negative insofar as this paper is concerned and are therefore omitted. The microscopic study served only to confirm our gross findings.

CONCLUSIONS

1. A brief discussion of chorio-epithelioma and herpes gestationis is presented.
2. A case combining both of these unusual conditions is herewith reported.
3. In reviewing the literature one other similar case was found.

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New Books.

The following books are among those recently received by the Library of the Medical College of Virginia. They are available to our readers, under the usual library rules:

Boyd—The pathology of internal disease.

Clark-Kennedy, A. E.—The art of medicine in relation to the progress of thought.

Felsen—Bacillary dysentery, colitis and enteritis.

Gradwohl—Clinical laboratory methods and diagnosis: a textbook on laboratory procedures with their interpretation.

Harris, Ed.—Vitamins and hormones. v. 111. 1945.

Huff—A manual of medical parasitology.

Jaffe—Men of Science in America.

Ministry of Pensions—Artificial limbs. 1945.

National research council—Inadequate diets and nutritional deficiencies in U. S.

Pulay—Constitutional medicine and endocrinology. v. 1, 1944.

Underwood—A textbook of sterilization.

Williamson—Physician, heal thyself.

Medical Literature for the Veteran Physician.

A special compilation of informative literature on recent developments in endocrinology is being presented to each physician returning from service in the Armed Forces during the War, by the Schering Corporation, of Bloomfield and Union, New Jersey, manufacturers of endocrine, diagnostic and other pharmaceutical preparations. The "Welcome Home" collection supplies information designed to help the military doctor bring himself up-to-date in civilian practice. It contains a copy of "Sex Endocrinology", the illustrated 96-page volume covering the physiology, chemistry and rationale of hormones in modern therapeutics. A "Handy Index" provides in brief outline form for the physician readily accessible and concise summaries on treatment and dosage of endocrine products.

MANAGEMENT OF PSYCHOTIC PATIENTS IN A GENERAL HOSPITAL IN PACIFIC AREA

A Study of 155 Consecutive Admissions

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and
S/SGT. W. B. STEVENSON

INTRODUCTION

The fruits of war are often revealed as vividly by the shivering or enraged psychotic as by the more obvious physically maimed and dead. In an evaluation of war psychoses, one is involuntarily brought to consider those of the civilian type. A direct comparison of these types, however, would be just as difficult, and as fair, as an appraisal of the similarity of the European and Pacific battle fronts. One is immediately impressed with the age factor in the problem of war psychoses inasmuch as these are of youth and therefore only in incipiency. Because of their youth, it was expected that most patients would show a schizophrenic reaction pattern. Also because of the severe resentment of the schizophrenic to regimentation, the paranoid type was consequently expected to predominate. This was borne out by the statistics, in that 54.8 per cent of the study were schizophrenics and of these one-third were of the paranoid type. (The diagnosis of the schizophrenics was subdivided in the following categories: simple, hebephrenic, catatonic, paranoid, schizoaffective, and schizoid types.)

While civilian psychoses range from the simple to the most complicated (and seemingly most hopeless) of types, the psychoses of the military are relatively minor and consequently give to more favorable prognoses. The diagnostic error, is, however, doubtless greater in the war psychoses. This is to be attributed to the apparently undramatic onset of some of these psychoses, limited time for observation and general mass fear of the soldier evidencing seclusiveness, irritability, inattentiveness, given to conversing in his day-dreams, somniloquences and showing a general picture of impaired efficiency. Faced by such a patient it is the duty of the Army psychiatrist to decide almost at once as to whether or not this is a temporary mental aberration; and, at risk of possible harm by the patient to others or to himself, to determine whether to retain the soldier after short therapy or evacuate for longer treatment and eventual disposition. When there are developments of the hallucinatory and delusional mechanisms, which make the soldier see saints coming out of the treetops one by one and whispering to him, cause him to dive into an inviting pool from his cot and in so doing crack his skull against a tree just outside his tent, or to begin a search for his C. O. and others with a gun, the diagnosis is not at all difficult. The diagnostic difficulty concerns itself with the onset of conditions resembling simple schizophrenias, conversion manifestations or the mild affective psychoses. The soldier who, after long tropical service, becomes emotionally retarded, entertains ideas of self-destruction or portrays the characteristic picture of depression, after dengue, hepatitis and other debilitating diseases, seems to verge closely on the psychotic border and is indeed a problem. The sudden elation and ideas of grandeur occasionally seen in psychoneuroses or the perplexed individual who is entirely without perspective as to the war or his personal problems may well puzzle the examiner. One rarely encounters an organic reaction type not of luetic origin. The alcoholic and toxic psychoses are seldom seen. Strikingly enough, the hysterical reaction, as in hysterical depression, is so deeply rooted that it is almost impossible to differentiate between it and a severe bona-fide depression. It is of interest to observe the considerable number of prison-psychoses and psychoses with psychopathic personality found among prisoners with relatively short confinement sentences. The inadequacies of the above types of individuals become so acute and marginal that they apparently find outlet in those escape mechanisms so typical of true psychoses. The relatively small number of women in the armed forces precludes mental illness characteristic of their sex. Of these one may think of the psychoses of an endogenous nature, the post-puerperal reaction types, the involutional, and general melancholia.

SOME PRECIPITATING FACTORS

The resemblance of war psychoses to those of the civilian types precludes an assumption that military

service in general, and more particularly tropical service, is responsible of itself for causing a mental breakdown. Students of human behavior are well aware of the fact that any trauma, be it sudden blast, exhausting maneuver march, a superior's reprimand, the harrowing fear of combat, jilting by a girl friend, sudden death of a parent, depressing or disturbing mail (whether with or without proper reason), or any other condition that affords a deliverance from the conflicts of warfare so typical of psychoses, may precipitate a full-blown mental aberration in a predisposed individual.

Some precipitating factors, however, deserve brief mentioning. As there are physical allergies, also are there emotional allergies for the potential psychotic. (In a household which has suffered hanging of one of its members, unpredictable consequences may be expected of the request to "hang up a coat".) In the case of the sensitive soldier in foreign service, his behavior may well be likened to that of an acrobat on a tight-rope, balancing himself precariously with a pole. The soldier may likewise attempt to balance himself emotionally, and combats subtle changes productive of possible loss of calm, position and personal safety by using a balancing pole of civilian affections, libidinal fixations, mail call, and generally good military adjustment to equalize the burden of military service. In such an individual, however, this "tight-rope" walking is exceedingly difficult and his inevitable fall (escape from reality) is certain.

Although mental illness is not conceived of as being infectious, the psychic contagion of the military environment is significant. Where people are closely quartered, every emotional disturbance of the person at the particular time is keenly observed and its impingements on both friends and enemies. The news of the death in one serviceman's family, or the changed affection of a supposed fiancee, the news of sudden wealth, as well as a periodic stream of soldier-patient evacuations to the U. S. because of vague somatic or nervous complaints have almost as pronounced a contagious effect on the group as a terrifying cry in the dark. The early childhood and later schoolroom and schoolyard techniques of banter and other forms of ostracisms carry over the adulthood and certainly express themselves in the confines of the military. There, men are apt to call "Speedy" or "Smoky" persons who may be showing signs of introversion; the obese, "Tiny"; "Quiz Kid" for the intelligently curious; and "Queer" to cover many cases, more especially those of sexual aberrations and even of abstinence. The social pressures of the military are not likely to be subtle, and have their effect in either bringing conformity or greatly furthering the social distance between the unfortunate target and his more conforming accusers. This serves not only as a focus of attention but demonstrates the principle of psychic infection both for the individual target and others in the group. Rumor and humor are the prize stallions of military delivery and they may surpass radio in spreading pure gossip or truth fragments with its concomitant effects on the person and organization.

Consequently, in the search for causative factors, we are led to the conditions whereby the individual may first display his psychotic behavior in military uniform. Here it is well to consider that it is no accomplishment on the part of either the inductee or enlistee to slip past the cursory examinations of a rather loose psychiatric net, inevitable in a fast-expanding war machine, by withholding or denying significant information as to his past, along with factors of amnesia, confusion, and their effect on the securing of reliable and complete, though subjective, case histories. It is of interest to note that a distinct effort has been made by some of the patients seen here to conceal evidences of their past breakdown. (The same applies for pure epileptics.) These men in their moments of lucidity are both conscious of and sensitive to their inferiority and ineptness and therefore actually seek military service as an escape channel to rectify past maladjustments. (One can here reflect on the possible basis for that song, "The Army's Made a Man Out of Me".)

The arbitrary standards of "good" and "fair-poor" were chosen for the appraisal of the educational and more embracing social history of the individual patient. "Good" educational background was evaluated from the standpoint of academic attainment exceeding the tenth grade, or its equivalent. Likewise, "good" social background was adjudged on the basis of past happy and efficient adjustment by the soldier-patient to his environment. Though social and educational factors are apparently related, they were evaluated separately. This is rather evident from the statistics where it was again revealed that education was merely a determinant and not the absolute correlate

with satisfactory social adjustment. Because of the very flexible margins of both the "poor" and "fair" as standards of appraisal, these two were combined to better demonstrate the greater contrast between them and the more definitely "good". Thus it was seen from the statistics that the whites seem to have a much higher percentage in the "good" classification of both educational and social background.

The home situation as affected by marital infidelities, separation, death, sib and parental disaffections along with general conflicts, was given attention. Though other seemingly important social features such as religion, marital status, occupation, arrests, and deleterious habits were considered, these were found, as anticipated, not to be pivotal in affecting to any marked extent the precipitation of a psychosis.

While 75.5 per cent of the total group revealed "fair-poor" social (or environmental) backgrounds, the figures for the negro were somewhat higher at 86.4 per cent than for the whites at 68.9 per cent; 23.7 per cent of the negro group and 59.4 per cent for the whites with an average of 45.8 per cent evidenced "good" educational background.

EVALUATION OF FINDINGS

The statistical analysis discloses a relatively slight variation in the age of mental collapse occurrence in negro and white soldiers. The breakdown onset for the negro soldier is 24 years 10 months; and 24 years 2 months for the white, thus averaging 24 years 5 months for the total group.

The total average length of military service is approximately 25.8 months, with an average length of tropical service for the entire study at 13.8 months, thus indicating that at least one-half the service time was spent overseas. It was shown that tropical endurance was somewhat higher for the white soldier by several months, but here again the factor of negro troop allocations seems to enter and to counsel against definite assertions. The combat statistics for negro and white approximate each other to two (2%) per cent; 45.8 per cent of the total group had experienced combat.

Rank, ranging from that of Pfc to Captain was evidenced in 40.7 per cent of the total study, and furnished additional interest to the study but proved of doubtful significance inasmuch as the factor of demotion was found to have asserted itself either in the past or just prior to hospitalization, possibly because of misguided attitudes. In this study, 4 per cent of patients seen had served or were serving time for court martial offenses prior to hospitalization.

The physical appearances of the psychotic patients, which according to some authorities is considered to correlate with certain types of mental aberrations, was not distinctive in this study. The patients ranged in bodily habitus to as marked an extent, regardless of diagnosis, as that of any group of men seen on a dance floor. From those mentally retarded these patients ranged to those of superior intelligence, voicing impressions and opinions of considerable thought-content. A case in point was that of one patient who quoted poetry fluently and logically discussed the philosophy of Plato and others, and the glory of the ancient world, with sound implications for that of the present. There were some with marked abilities in the field of art, some with unusual mechanical dexterity, others with generally superior abilities and comprehension, along with some rather bizarre inventive schemes. Here comes to mind one patient's plan, actually proposed to several generals, for a giant landing craft with caterpillar treads and bristling with 155 m.m. and other large guns to carry an entire invasion party over water and then to proceed over enemy land bastions with uninterrupted speed and fury. The range of civilian occupations among these patients was dispersed from stooge, racketeer, professional dancer, skilled technicians, salesmen, to a medical officer. In the Army these men were employed in positions ranging from labor details, signal tower operator, other positions of responsibility, to combat leadership with its decisions for life and death.

Despite the fact that Army psychiatry is relatively simple, frequently involving itself with hospital recidivists, there often appear some of the rarer syndromes. In a case of paranoia, the college-educated patient was very much occupied with all manner of systematized delusions ranging from stealer evolution to composition of the human family group, the growth of hair, and prediction of mosquito reproduction over certain time periods, all with an expressed relativity, and with the self-alleged intent of evoking some changes through his dormant but superior powers as one of the world's great scientific benefactors. Folie a deux was seen in an officer and an enlisted man with the severe depressions precipitated by the fatal ambushing and torture of

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their mutual friend. This psychiatric rarity was even more interesting inasmuch as the patients were not acquainted before hospitalization and in that both showed marked improvement in their condition after their mutual stuporous mutism and severe confusion.

As expected, the hostilities shade the psychoses. Here it is well to observe the racial antagonisms. Individuals belonging to minorities would synthesize their racial sensitivities so acutely that very often a definite minority psychosis was expressed. This was more evident among negroes than in whites. Of special interest are such individuals as the mulatto, the newly arrived immigrant, the person of foreign birth, or the semi-assimilated members of our society who may still feel the chill and fever of the residual minority oppressions and whose psychoses may be said to approximate those of "marginal man". For example, the case of the young Chinese recently emigrated to the U. S. A. and shortly thereafter ushered into a realistic and, to him disorienting war machine who evidenced ambivalence between Chinese ritualistic dances and postures and muttered affirmations of being an American; that of the very evident social malaise of the keenly sensitive foreign-born American and his seemingly perpetual seclusiveness; the general distrust of the Navajo Indian patient whose paranoid trends regarding the white man were carried over to suspicion and antagonism for ward procedures, from simple medication to custody of his personal belongings; and, more markedly, the cases of several mulatto patients whose racial marginality was expressed in repeated fights and other compulsions with both negro and white. Also as evidenced by the expressions of the entire group, the resentment was greater for the Army than for personnel, possibly indicative of fairness and generally good effort to attain sympathetic understanding by military authorities. The degree of regression in many patients approached that of the suicidal border. Although many had harbored thought of self-destruction, only a few vain attempts were made.

THE DREAM LIFE OF THE PSYCHOTIC

The dream life of the various nations goes back to pre-Biblical days and has been elaborated on extensively by writers from Aristotle and others to the present-day purveyors of "dream books". That dreams have real significance in everyday behavior is evidenced by the common curse among some peoples for their enemies to have "bad dreams" or to have their own vexing dreams changed to benign. Oneiroscopic history touches upon some of the world's foremost figures and events from the Biblical famine foretold in a dream (and consequently regulated) through to the many contributions to art, science, literature as an aftermath of dreams, and is seen demonstrated frequently by the dramatic technique of portrayal in retrospect. And so dreams figure somewhat in diagnosis and therapy.

As in the "normal" individual, the dream of the psychotic is likewise compatible with his type of mentation. The harrowing sensation of being pinned against a brick wall by a Nazi taxicab over having "Bronx-cheered" der Fuehrer in a Wilhelmstrasse theatre was a dream of a normal antifascist. The dream of being interrupted in coitus with his wife by male onlookers who also poured cold water on their genitalia was that of an individual disturbed by the sudden loss of his wife's affections, a loss symbolized by this revealing dream.

In the psychotic, regression from reality is frequently disclosed by dreams. The problem of sex, so poorly managed by the schizoid individual, is quite prevalent in the dream state and represents the chief type of dream for the study. The symbolism of these dreams is vividly illustrated in the presence of snakes, mountains, valleys, flying or hovering, strange landscapes seen before. There is the recently observed example of a dream of fifteen (15) years' persistence in which the person sees himself walking alongside a white picket-fence and then falling into a manhole, with others falling on him and smothering him. The interpretation of the picket-fence as well as of other pointed objects is clearly explained by students of Freud. The magnitude of the environment and the feebleness of the simple schizophrenic is well illustrated in the dream, of long history, wherein the person stands at the end of a smooth asphalt road, sees a ball start rolling towards him getting larger and larger and then watches both ball and road crumble just a short distance from him, leaving him either to awaken in a cold sweat or to experience this spectacle one or more times again in the course of the same night. A manic's dream is exemplified by the supporting of great weights in one hand as he swings, in the best Tarzanic tradition, from treetop to treetop. In those patients who have experienced combat, dreams

are augmented by terror sensations, as when the person sees the river turning to blood and his drowning therein, or sees tombstones, one bearing his own name.

GENERAL CONSIDERATIONS—PREVENTION

Since the origin and cause of mental illness still remain unsolved mysteries in medicine, one can speak only of relative prophylaxis. One means is to prevent the induction or enlistment of the potential psychotic. While this is an exceedingly difficult task, wide vigilance should be instituted not only from the standpoint of sound military economics but more basically for the prevention of individual mental breakdown and its concomitant personal tragedy. Every exacerbation, even of a physical nature, is hardly beneficial for a patient already sensitized to a given disease, not to mention mental sensitivity in which the emotional trigger is always fixed for discharge. Particular care must be undertaken at induction centers to obtain good social histories and to afford better psychiatric appraisal through more thorough examination. The psychiatric net, though severely stretched by the mass of cases, can well be repaired. Furthermore, a more understanding attitude on the part of line officers, so frequently accustomed to behavior interpretation from an "AR" point of view, may well prevent many a breakdown. When in doubt, a psychiatrist should be allowed to decide as to whether the soldier is deserving of punishment, and, if so, whether confinement should be in a stockade or hospital. Another measure of prevention goes beyond the induction center and concerns itself with the possible education of "people back home" in writing to their servicemen. In addition to the factor of infrequent mail, there is the steady stream of sobbing mail with its irrelevant and depressing details, not to mention the possible misconstruing of even a single sentence—and its most profound possibilities in causing the soldier to begin his slide towards a mental aberration. This factor is frequently mentioned by the unfortunate soldier beset with mental illness.

THERAPY

The old concept of Father Time as the greatest healer holds as true of psychiatry as of other branches in medicine. Although not of itself the complete curative agency, yet time is distinct in affording opportunity for the patient to untangle himself emotionally, and, consequently, become more amenable to therapy. Also of importance is the hospital environment of the newly-arrived, bewildered, agitated, and frequently restrained patient. This new environment must not only have the necessary physical comforts but must also possess the kindly understanding on the part of personnel that such patients are truly sick, and that the mental aberration, which at times is temporary, betokens illness as much as the visible physical wound.

This hospital's closed psychiatric section consists of three buildings; one for the violent, with individual locked and reinforced rooms; one for the moderate psychotics with individual rooms which are neither reinforced nor locked; and a third, a regulation open ward structure with one front door which, of course, may be locked. The first two wards are not enclosed in a stockade, but have an adjoining fenced volley-ball court, play yard, and a garden. In each of these wards there is also a centrally located day room with its reading and writing facilities and opportunities for indoor games, its ping-pong table, and a phonograph. For benefit of discussion we shall call the wards, E, F, and G.

Upon arrival, the patient is admitted to Ward E, where he is subjected to the usual admission routing of a short and informal meeting with the ward officer, along with good food, medication, and a rest. After almost immediate and hasty perusal of the history, the patient is informed that better accommodations are available subject to his good behavior, with the basic understanding that his present address is in no way to be considered as punishment. This original interview is closely followed by understanding attention on the part of ward personnel. The daily schedule of activities, supervised and actively participated in by nurses and corpsmen range from routine patient care to assignment on simple details, participation in volley-ball or ping-pong or other games, and visits to the movies. If progress permits the patient is transferred within a couple of days to the less restricted Wards F or G.

Although everything is carried on in an informal and friendly manner while the patient is still seemingly in his mental twilight, the atmosphere of an Army hospital is still sustained. While his needs are being satisfied in the early stages, his responsibility mounts upon transfer to the less restricted Wards F and G, where his treatment approximates that of the average hospital patient. Despite popu-

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lar misconceptions as to behavior of psychotic patients, there was generally wholehearted cooperation with ward details, landscaping, and many another chore so readily accepted by practically all the patients.

Concerning medications, the rule was generally to give as few hypnotics and narcotics as possible. The former were rarely given in daytime, the latter only when the patient exhibited violence or on the day of evacuation. It is here worthy of note that because of this general management of the patient, not once was it necessary to restrain a patient of this series by the time of his evacuation. (The average period of hospitalization was about 1 month.) With the beginning of electroshock therapy, management of patients was greatly simplified and restraints modified. Wet packs or continuous bath treatment were not resorted to with the general result that the closed section differed little from the open wards. In a rather large group (about one-third of the total study) treated with electroshock and given an average of about five treatments (some receiving ten treatments and a few only one treatment), some heartening results were obtained. There were several cases of almost complete restoration of normal mental functions with just one treatment, closely followed by psychotherapy, while seventy-four per cent (74%) treated with this effective and seemingly dramatic form of therapy showed progress from definite improvement to virtually complete recovery. Reassuring advice and psychiatric bolstering for the patient who was afraid or showed other evidence for their need were other therapeutic devices of great importance. One patient felt greatly relieved to be able to hand to the examiner a long list of names (41) and addresses of enemies, with the certainty that these would torment him no further. Some work in group therapy was also attempted and showed promise of benefit for the milder and more accessible psychotics. This device made possible some re-orientation and education of the total group, possibly giving to each patient the conception that what had happened to him had also happened to others; and that his problems were similar to those of others. This subtle invitation to understanding furthered mutual sociability and discussion.

The patient's time was utilized to seemingly good advantage by the considered scheduling of the day's activities. Patients became quite proficient in ping-pong, volley-ball and other games. (One catatonic responded only to close order drill.) In general, ward details, gardening, and landscaping were benefited as they in turn seemed to benefit the patient. Best results were achieved, as expected, in craft work of a mild competitive nature. Informal musical therapy was also attempted and was of general appeal to the patients. General improvement by the time of evacuation was noted in 67.7 per cent of the negro patients, 57.3 per cent of the white patients, and 61.3 per cent of the total patients studied.

The above bears out to some extent the generally accepted opinion that among primitive races, the psychoses are of a less complicated nature, thus, also, the higher percentage of recovery.

SUMMARY

A review of the case histories leads to the view that predisposition to mental illness in civilian life may well eventuate in breakdown in the more rigorous military environment, and probably at an accelerated rate. However, the prognosis for these patients is much more favorable than for those of civilian life because of such factors as incipiency, generally good physical condition of the patient, along with prompt medical attention and supervision.

In contrast to the view that mental patients are "poor protoplasm" it is well to consider that many soldiers with psychotic episodes or illness have volunteered for military duty, possibly out of mixed patriotism and opportunism. Most of these soldiers had good records. Almost one-half (45.9 per cent) of the group were with combat experience; had spent on an average more than 25 months in the service and more than 13 months in foreign service with its rigors and tensions and seemingly small prospect of resumption of longed-for civilian life. Also, that 40 per cent held some rank is generally indicative of their worth. Once hospitalized and properly treated, these persons proved themselves ideal patients and almost invariably expressed desire for return to duty. In contrast to some slight effort on the part of some psychoneurotics to escape military duty, the malingering factor in the psychotics was practically negligible.

The dream life of the psychotic patient afforded further insight into the mental aberration, with which it evidenced compatibility. An escapee from reality or flight into the outer sphere is sought dur-

ing the waking state, so this same type of mentation is continued in the dream life. Among those who have experienced combat, terror and battle dreams seemed to predominate. In the schizophrenic, the sexual symbolism was almost invariably present. These dreams worried the patient a great deal, were often volunteered by the patient for interpretation and diagnostic aid; yet, with an adjustment to hospital routine, they failed to unduly distract him.

It was indicated that a restricted administering of narcotics and hypnotics, along with a properly scheduled complete day of wholesome activity, and rather thoughtful and individualized treatment of patients by capable personnel produced marked therapeutic results.

CONCLUSIONS

1. The stress of military life is not entirely responsible for mental collapse.

2. The seeming inevitability of psychotic breakdown is contrasted with the preventability of some psychoneuroses.

3. The fair-poor social background of 75.5 per cent of the study group seems of greater importance than even the detrimental hereditary factors evidence in 57.4 per cent of the total group. The educational background, however, seemed to be of little importance since almost half (45.8 per cent) even had a "good one".

4. True organic psychoses represented less than 2 per cent of the group studied. (It was further considered that 16.1 per cent of the patients studied gave past history of malaria and of dengue which may be considered as coincidental.)

5. Over one-half (54.8 per cent) of the patients were schizophrenics and one-third of these were of the paranoid type, while in the affected reaction types the depressive was observed to predominate.

6. There was a marked predominance of psychotic trends with the C.P.S. plus a relatively high percentage (4 per cent) among these patients of military punishment and stockade confinement.

7. The great value of electro-shock therapy was emphasized for selected cases as both a management aid and as a therapeutic agent.

8. Attention was directed to the relative ease of mental patient management with adequate facilities and proper understanding of the person who suffered breakdown.

9. A more favorable prognosis was noted for psychoses in the Army than for those of civilian life.

Floral Eponym (39)

FUCHSIA

LEONARD FUCHS, 1501-1566

Fuchs graduated M.A. at Igolstadt in 1521 and M.D. in 1524. After practicing 10 years in Munich he accepted a professorship at Igolstadt. In 1528 he resigned this to become the chief physician to the Margrave of Anspach. In 1535 he accepted the chair of medicine at Tübingen, which he retained until he died. He was a fervid Hippocratist, but is better known as a botanist. His *De Historia Stirpium* (Basel, 1542) is beautifully illustrated. His name was given by Plumier to the genus *Fucksia.*

Fuchsia is a genus of the family Onagraceae. Most of them are natives of Central and South America, a few are found in New Zealand. They vary in size from potted plants to small trees. *F. excorticata* of New Zealand grows to 30 or 40 feet in height. Fuchsias are among the most ornamental of the cool greenhouse flowering plants. They may also be used in summer as bedding plants, and they are among the very few flowering plants that will bloom in the shade. They were extremely popular in the past century, and at present are regaining their popularity.

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SPOROTRICHOSIS—REPORT OF A CASE IN VIRGINIA*

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The first case of sporotrichosis seen at the University Hospital with the probable source of infection in Virginia was admitted on January 24, 1945. A survey of the literature reveals that only one other similar infection has been reported from the State. That the occurrence of sporotrichosis is relatively rare in this section is suggested by the paucity of reports from Virginia, West Virginia and North Carolina. There have been no case studies available from South Carolina. See Table No. 1.

Sporotrichosis is a chronic infection caused by the fungus, Sporotrichum schencki, first carefully described in this country by Schenck in 1898. The geographic distribution in the United States is widespread, with the preponderance of cases reported from the Mississippi and Missouri valleys.

Several classifications of the clinical types have been offered, the most important of these depending on the work of de Beurmann and Gaugerot. In general, the various forms are:

1. The localized lymphatic type which may be associated with the sporotrichotic chancre.
2. An epidermal type—ulcerative or non-ulcerative in character.
3. The extracutaneous forms involving mucous membranes, the skeletal system or visceral sites.
4. The disseminated type, rarely seen in the United States.

Differential diagnosis includes the chronic granulomas, particularly syphilis, tuberculosis, drug eruptions and pyogenic infections. In this locality, tularemia of the cutaneous type must be eliminated. In the latter, although a primary lesion and nodular lymphangitis may appear, satellite lymphadenopathy and a definite systemic reaction are prominent features.

The diagnosis depends on cultural studies, using Sabouraud's glucose agar and blood agar, since the organism is rarely demonstrated in fresh preparations from the lesions. Histologic examination is usually non-specific. Intracutaneous tests with sporotrichin may be of value in the establishment of a diagnosis; agglutination tests may elicit a positive reaction but technical difficulties have obviated their general use.

Mrs. E. T., a white housewife, age 58, a resident of Louisa County, Virginia, was admitted on January 24, 1945. The patient had been referred by her local physician for the diagnosis of indolent ulcers and nodules of the left hand and arm, present for approximately one month. About December 15, 1944, a small "pimple" had appeared on the fourth finger of the left hand. This lesion had in-

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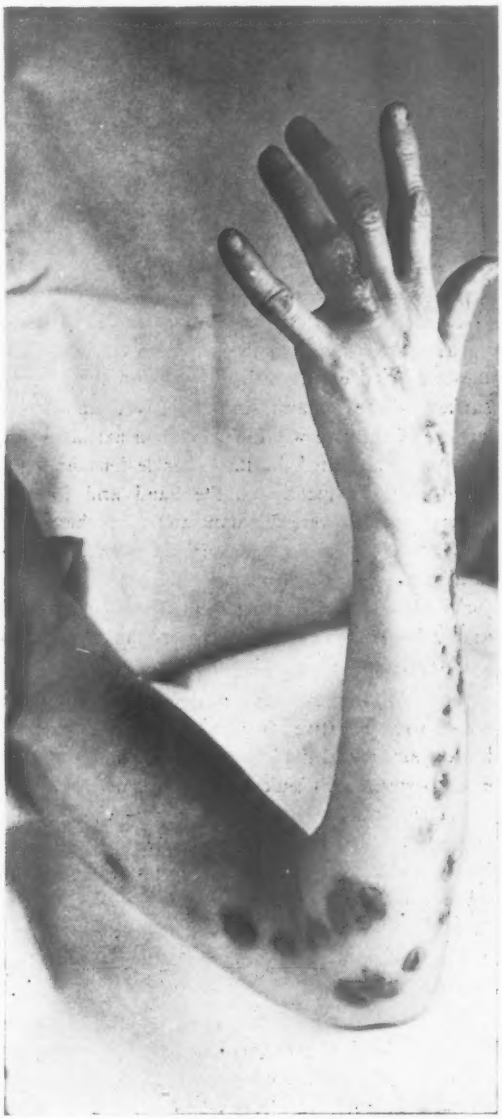
creased in size and had ulcerated within one week. Several small, red nodules were then noted over the dorsum of the hand followed by a progression to the extensor surface of the forearm and the medial surface of the arm. Several of the lesions had ulcerated during the fourteen day period prior to admission.



Approximately one week after the lesion had appeared a doctor was consulted and a paste was applied locally without improvement and with extension in the findings. One week later the patient was seen by another physician who drew serum for agglutination tests with B. tularense with negative findings. Treatment had consisted of antiseptic compresses and later sulfanilamide powder which produced a dermatitis; the patient also was given sulfathiazole by mouth. There was marked tenderness of the lesions as well as an associated pruritus which had appeared only after the development of the sulfonamide dermatitis.

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The patient stated that she had not been out of rural Virginia for several years. In addition to her household duties, she worked in a country store and in a garden, where she had recently handled straw while mulching rosebeds.

The remainder of the history was non-contributory.

The patient showed no evidence of an acute illness. The temperature was 98.4 F. The pertinent findings were referable only to the skin lesions. On the dorsal surface of the proximal phalanx of the fourth finger of the left hand was an indurated granulating ulcer (9.5 x 2 cm.) with irregular edges discharging a viscid, grayish-yellow pus. An area of erythema and crusting surrounded the lesion and the entire finger appeared edematous. Subcutaneous nodules varying from 0.5 to 1.5 cm. in diameter appeared just distal to the wrist on the dorsum of the hand and extended in a chain on the extensor surface of the forearm, and radially to the medial surface of the arm within 9 cm. from axilla. Ulceration had appeared in the older lesions and was noted more frequently on the hand and forearm. Several nodules were fluctuant and from these thick gray-green pus could be aspirated. On the upper arm there was less evidence of fluctuation, the majority of lesions remaining firm. (See Figures 1, 2, and 3.) There were no palpable epitrochlear or axillary lymph nodes.

The Wassermann and Kahn reactions of the blood were negative; a urinalysis was normal; a blood count revealed 12.5 gm. hemoglobin, 4,040,000 erythrocytes, 5,200 leukocytes with a normal differential smear. The sedimentation rate was 30 mm. in sixty minutes. Agglutinations with B. tularense were negative. An intracutaneous test with tuberculin in a dilution of 1:1000 was negative in 48 and 72 hours. A roentgenogram of the chest was normal.

The following studies were reported on the cutaneous lesions:

Direct smears from the ulcer on the finger revealed occasional gram positive cocci in pairs and chains; cultures demonstrated only staphyloccocus aureus hemolyticus and micrococci. Under sterile conditions pus was aspirated from a subcutaneous nodule above the left elbow on the medial surface of the arm. Direct smears revealed no fungi or bacteria. Sabouraud's glucose agar was inoculated with this material on 1/24/45. On 1/29 white, moist yeast-like and flat hyphal growths were present. On examination through the flask at low power a filamentous fungus producing small blastospores was observed. On January 31 the color of the culture was changing to brownish black and on February 3 the entire growth had assumed this pigmentation, the surface appearing convoluted and membranous.

Slide cultures revealed delicate hyphae showing spindle-shaped, elliptical, ovoid and round conidia at the ends of the lateral branches supported on conidiophores, identified as S. schenki.

Histologic examination of lesion from the forearm showed that the epidermis was intact. A considerable increase in the collagen fibers and capillaries of the papillary bodies was present. The upper portion of the corium was replaced by a subacute granulomatous inflammatory reaction, consisting of many tiny accumulations of polymorphonuclear leukocytes which were undergoing disintegration. These were surrounded by a zone of mononuclear cells many of which were elongated, producing the structure of epitheloid cells. Capillaries and small amounts of hemorrhage were seen in these areas. Peripheral to the zone of epitheloid cells was granulation tissue which formed a large part of an inflammatory mass, consisting of capillaries resting in a mesh work of connective tissue cells and infiltrating neutrophiles, mononuclears, lymphocytes and plasma cells. No organisms were demonstrated in the sections.

During the period of hospitalization, the patient continued to complain of moderate pain in her arm and hand. She felt well generally, however, and her course was essentially afebrile. Local treatment consisted of 5 per cent ammoniated mercury ointment. On January 30 a daily oral dosage of 6 grams of potassium iodide was prescribed and the patient was discharged two days later with little change in her status.

On February 14 a 50 per cent regression of the lesions had occurred and at this time the potassium iodide dosage was increased to 12 grams daily. On March 14, complete healing had occurred except for mild induration at the sites of former activity. Iodides had been discontinued one week previously because of a mild gastrointestinal reaction. The patient was advised to resume a dosage of 3 grams daily and referred to her physician for continued observation.

TABLE NO. 1

REFERENCE	AGE	SEX	COLOR	OCCUPATION	POSSIBLE SOURCE	DURATION	TYPE	LOCATION	LABORATORY STUDIES
VIRGINIA									
Shaw, F. W., and Kimbrough, R. D.: *Va. Med. Monthly* **58**:384, September, 1931	22	F	C	Housewife	mosquito bite	2 months	Lymphatic	Left arm	Cultures positive STS positive
WEST VIRGINIA									
Wade, J. L., and Matthews, A. R. K.: *Arch. of Int. Med.* **61**:916, June, 1938.	20	F	W	Housewife	trauma?	14 months	Epidermal and Mastitis	Right & left Breasts	Smear doubtful; cultures positive; STS negative
NORTH CAROLINA									
Fogd, D. H., and Martin, D. W. *J. of Ped.* **17**:193, August, 1940	7	F	W	Student	contact with dead rat	3 weeks	Lymphatic	Left hand & arm	Cultures positive; Biopsy "chronic and acute inflammatory in type." STS negative.
Noojin, R. O., and Calloway, J. L.: *Arch. D. & S.* **49**:305, May, 1944	36	F	C	Housewife	not determined	5 weeks	Lymphatic	Face & Neck	Cultures positive; Biopsy "chronic inflammatory reaction." STS negative
	13	F	W	Student	Exposure to shrubbery	2 months	Epidermal	Lower left leg	Cultures positive STS negative
	14	M	W	Farmer	trauma	2 months	Lymphatic	Left hand & leg	Cultures positive; Biopsy "no evidence of causative org." STS negative
	38	M	W	Farmer	not determined	3 months	Lymphatic	Left hand & arm	Cultures positive; Biopsy "no fungi"; STS negative
	11	F	W	Student	Scratch on thumb picking cotton	2 months	Lymphatic	Left hand & arm	Cultures positive; Biopsy: "no definite fungi." STS negative

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Ciba Paintings on Exhibit.

A tribute to the medical profession is "The Seven Ages of a Physician," a series of seven paintings by the contemporary artist James Chapin, which will be on exhibit at the American Medical Association Convention in San Francisco, June 28 to July 7.

The display will be held in the San Francisco Museum of Art in the War Memorial Building, where many of the convention meetings will take place.

Mr. Chapin, who holds an enviable position among the leaders in American art, was commissioned by Ciba Pharmaceutical Products, Inc., to paint the series, which paraphrases Shakespeare's seven ages of man. Works by Chapin are included in the collections of outstanding museums throughout the country as well as in the private collections of many famous art lovers.

First in the series is "The Doctor's Son," showing an infant child attempting to reach for his father's stethoscope; the second, "The Dying Hare —A Boy's Dedication to Healing," vividly portrays a youth overcome with remorse at having wounded a hare and filled with a desire to make whole the creature which he destroyed. And so—the wish becomes a resolve and dedication.

The third painting entitled "Medical Education —The Bedside Lecture," depicts for a group of medical students the relationship between doctor and patient. The fourth, "The Doctor," illustrates the role of the doctor as an arbiter of birth, healer of the sick and maimed and comforter of the aged.

"The Doctor in War" is next in the series. This was composed with some of the earlier religious pictures, the "Pietas", in mind. The doctor and nurse are seen as ministering angels, inclining above a suffering figure in the foreground. The desperately wounded worker, whose posture suggests crucifixion, is supported by both a white and a negro soldier, symbolic of the fact that in the realm of medicine as in true religion no racial barriers are recognized.

Following this is "Research Heroic—The Self-Inoculation." The picture conveys the heroism of numerous doctors, who, unwilling to endanger others, have experimented on themselves in their search for new serums to prevent or cure disease.

The last painting, "Doctor's Heritage," is an effective study of an elderly physician and a student doctor, seated at a table on which lie a book, skull, globe and test-tube—symbols of knowledge, the endless battle against death, the World as province and the future of medicine.

CERTAIN FACTORS TO BE CONSIDERED IN THE SURGICAL THYROID

HYMAN CANTOR, M.D.*
Petersburg, Virginia.

The cause of hyperthyroidism is hyperplasia. The thyroid gland is firm in hyperthyroidism. If the gland is not firm on palpation, the patient does not have hyperthyroidism. To palpate the thyroid, the larynx is pushed over with one hand and with the other palpating hand, one finger is placed in back of and one in front of sternomastoid as the patient swallows. The thyroid gland being displaced can be felt as it goes up and down.

INDICATIONS FOR THYROIDECTOMY

1. Primary thyrotoxicosis, as result of exophthalmic goitre or primary Graves' disease, and toxic adenoma.
2. Secondary thyrotoxicosis, as result of previous goitre usually occurring in younger subjects, or toxic adenoma.
3. Non-toxic adenomatous nodule, potentially malignant.
4. Aberrant thyroids potentially malignant. Lingual thyroid occurs in this class and is characterized by central swelling at back of tongue. Masses running along sternomastoid muscle should be removed and treated with irradiation.
5. Colloid goitre, particularly indicated for pressure and also for cosmetic reasons. A small percentage may become toxic.
6. Riedel's disease, a rare condition characterized by hard smooth mass producing symptoms by pressure of the enlarged thyroid gland.
7. Certain types of heart disease: Total thyroidectomy in these cases causes a markedly subnormal basal metabolism, thereby decreasing the load on the heart.

OPTIMUM TIME FOR THYROIDECTOMY

The most important single factor in determining the optimum time for thyroidectomy is an increase in body weight of the patient. The basal metabolism must be reduced to normal. If you operate with metabolism, more than + 20 the effect will be bad. It is not wise to operate on a patient who fails to gain weight or is losing weight, when the patient is emotionally unstable, when the patient has vomiting or diarrhea, when there is any increased severity of symptoms, or following acute infection. Cardiac decompensation should be properly prepared. Changes in blood calcium should be corrected by proper diet, giving calcium orally and intravenously, vitamins, thiouracil and iodine.

THIOURACIL AND LUGOL'S SOLUTION

Thiouracil has its greatest usefulness in the patient who is seriously ill with thyrotoxicosis. If iodine alone is used to prepare this type of operation, the mortality may be high. Iodine is contraindicated in the tuberculous patient. According to Dr. Frank Lahey, out of 1,000 operations a year on goitre, 100 to 125 will require thiouracil. If the patient does not require multiple stage operation and is in no danger of dying, she can be prepared with Lugol's solution in a week and can leave the hospital in another week.

The administration of thiouracil takes time and is risky. It requires close observation, but it has definite place in preoperative preparation of the surgical thyroid. Thiouracil will bring the metabolism to normal, but the histological picture is that of hyperthyroidism, for the hyperplasia remains. It is therefore difficult to perform an operation on thiouracil alone, because of the friability of the thyroid gland. Thiouracil exerts an extra-thyroid effect, while Lugol's solution is intra-thyroid. Iodine acts by depositing itself in the acini, compressing them and causing the cells to flatten. Thiouracil decreases the synthesis of thyroxine. It does something to inorganic iodine, making it not useful in the thyroid for the manufacture of thyroxine. As a result, the amount of iodine circulating in the blood is decreased and the metabolism comes down.

With the administration of thiouracil the time of operation is approximately as many days as the number of degrees the metabolism is above normal to bring the metabolism to normal. In a patient with metabolism of + 56, it will take 8 weeks to bring that to normal. In such a case give thiouracil for 7 weeks, but the last week no thiouracil, and for the last 10 to 21 days give Lugol's solution t.i.d. daily. This combination produces the good effects

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of both thiouracil and iodine.

The administration of iodine is followed by involution of the thyroid gland and decrease in size. The gland, instead of being friable and vascular, becomes pale and firm. Iodine is effective in toxic goitre and less effective in toxic adenoma. Thiouracil is effective in either. One must bear in mind that a non-toxic adenoma may be converted into a toxic goitre by administration of iodine. Iodine will never cause the basal metabolism to become subnormal. Thiouracil may result in myxedema. Some, therefore, believe that it may become the answer to hyperthyroidism.

Thiouracil may cause sensitization reactions, such as fever, chills, edema, swollen salivary glands, nausea, joint pains, skin eruptions, thrombocytopenia and agranulocytosis. Giving thiouracil for a while, ceasing to use it and then re-administering it, will greatly increase the sensitization complications that go with it. Every patient who takes thiouracil must have a weekly white blood count. The best single agent to combat agranulocytosis or other sensitization manifestation of thiouracil is penicillin.

COMPLICATIONS FOLLOWING THYROIDECTOMY

Parathyroid Tetany:—With removal of parathyroids the patient will develop parathyroid tetany from 12 to 18 hours post-operative. She will have carpopedal spasm within 12 hours. Treatment consists of giving calcium gluconate or chloride intravenously (the latter working almost immediately) and 2 c.c. parathormone. Since it takes ½ hour for parathormone to work, it should be given simultaneously with calcium intravenously. This is followed by ingestion of hitacherol, ten drops t.i.d., with dilute hydrochloric acid and calcium lactate. The acid makes the calcium more easily taken up. Once controlled, the dose of hitacherol, because of its expense, can be cut down to 2 to 4 drops a day. Parathyroid deficiency may come on late, causing stiffness of fingers at menstrual periods. The blood supply of the parathyroids being cut off by scar tissue is the cause of the delay in onset.

Post-Operative Hemorrhage:—When post-operative hemorrhage is visible on dressings, it is not dangerous, for it will be easily detected rather early. When post-operative hemorrhage is hidden, it is dangerous, for it isn't detected until complicating symptoms develop. It will cause obstruction to breathing and may cause death due to asphyxia. Not being able to deploy itself, the pressure under the deep cervical fascia becomes tense and small veins of the neck become compressed, causing edema and dysphagia. Edema of the larynx will cause edema of the vocal cords and may cause death due to inability of air to get into the lungs. It takes several hours for this condition to occur. The patient is restless and tries to sit up in bed. If this condition is missed and patient given morphine, his respirations may be further embarrassed. The first sign of this hidden hemorrhage, subsequent pressure and edema, is dusky cyanosis of face. This is accompanied or followed by sitting up in bed and using muscles of respiration and labored respiration. The immediate treatment is to get an airway down the larynx, to be followed by removal of the clot and stopping the bleeding.

Recurrent Laryngeal Paralysis:—If unilateral recurrent laryngeal paralysis is due to injury to the nerve, the patient will usually be hoarse as long as he lives. However, sometimes the other cord will hypertrophy and meet the paralyzed cord and thus relieve the hoarseness. If bilateral, the condition may be fatal because edema of both cords will not allow patient to breathe. The immediate treatment for this latter condition is intratracheal intubation and tracheotomy. Later on the aretynoid cartilages can be resected or a non-absorbable suture tied around each vocal cord and each cord pulled out.

Thyroid Crisis:—The etiology of thyroid crisis is unknown. It is seen in people inadequately prepared. Not all people are candidates for subtotal thyroidectomy in one stage. To avoid thyroid crisis, select the patient, time of operation and safe amount of surgery. Some patients are iodine fast or iodine resistant. In these patients there is a definite place for graded operation, tying off poles and hemi-resection. The patient with thyroid crisis does not respond to treatment and is 100 per cent fatal, but the patient with thyroid storm responds and gets well, for he will react to iodine. The treatment of patients with thyroid storm and also crisis is to pack the patient with ice, intravenous and subcutaneous glucose, iodine, fluids and adrenal cortex.

Medical Arts Building.

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FOREIGN BODIES IN THE VAGINA*

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Richmond, Virginia.

A few years ago a median sagittal section of the head of a cadaver was made in the anatomy laboratory at the Medical College of Virginia. There was a large perforation of the nasal septum. Lying partly in this perforation was a thin, tarnished dime and a rubber inner tube patch. The corpse had come from an asylum for the insane. We who viewed the dissection did not know the explanation of the presence of these foreign bodies. However, medical practice and medical literature contain many instances of foreign bodies placed wilfully or otherwise in those body cavities opening upon the surface. Thus, there are cases of foreign objects in the nose, ears, bladder, rectum, and vagina. It is with bodies from extraneous sources found in the latter location that this paper is concerned.

The literature contains reports of cases in each of which one of the objects listed as follows was found in an infantile or juvenile vagina: a metal container of crystals of potassium permanganate; an empty shell; hair pins; a stick; and "ear of grain"; a paddy grain; a straight pin; safety pins; the shell of a hazelnut; a cork; a wad of paper; a mass of calcium oxalate crystals, 6 centimeters in length and weighing 25 grams; a "forked branch of cherry"; a "piece of straw rolled up"; and a leech. One vagina was a veritable museum. It contained two cherry stones, two pebbles, two splinters of wood, some scraps of coal, and other foreign bodies. The latter case was only a runner-up to the following:

The collector and custodian in this case was a feeble-minded, colored pseudohermaphrodite, aged 23 years, who had on two occasions this remarkable collection: a hexagonal-shaped nut 1 centimeter in diameter, six shoe buttons, two rubber balls, the cap of a tooth paste tube, and a small cork. In another somewhat similar case the vagina of a 27 year old feeble-minded woman contained thirteen safety pins, three pieces of cotton, a large screw, and a large piece of coal.

Also reported are additional cases in which the vaginas contained the following: more buttons; hair pins; safety pins; a cylindrical tin box, 1¾ inches long and above 1 inch in diameter; pieces of cotton; a bottle 4½ inches in length; a sandstone 1¼ inches long and ¾ inch wide; a bael fruit, 3 inches in diameter; and a piece of ox tongue, 7 x 4½ x 2 centimeters. The titles of two Italian papers, unavailable to me, indicated that there were two more cases in which leeches were found in the vagina.

I recall, I think, two specimens which were in the Harvard Medical School museum when I was a medical student. They had been removed from vaginas. One was a large Irish potato and the other a ligamentum nuchae of an ox.

I once examined a negro woman who turned out to have carcinoma of the cervix. Her vagina was packed full of mutton suet. This was her method of treating the bleeding. My first thought was that this material was feces from a recto-vaginal fistula.

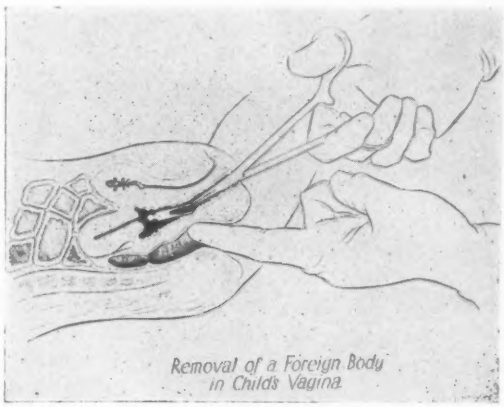

Fig. 1.—Method of extracting foreign body from child's vagina.

The largest animals which I have seen in the vagina have been pinworms.

Within the past few months several women have come to the office, each with a menstrual tampon unwittingly left in the vagina for a long period of time. One had had coital difficulty and had felt a mass. She suspected she had a tumor. She was a Ph.D. Another had had a foul discharge for four weeks. Soon after the onset of leucorrhea she 'phoned her family doctor and he prescribed vaginal suppositories and douches. These did no good. In each

*Read at a meeting of the Richmond Academy of Medicine, November 27, 1945.

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of the cases there was mild vaginitis and the tampon which was found was very foul. Another patient came with salpingitis which she attributed to a menstrual tampon which had been forgotten in the

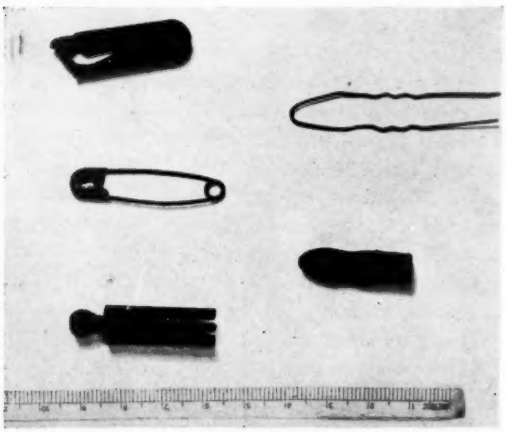

Fig. 2.—A diaper clip, safety pin, toy clothespin, hairpin, and metal pencil top removed in cases reported herein.

vagina for some time. A causal relationship seems unlikely but no specific organisms were found.

Pessaries are foreign bodies purposely placed. There are recorded cases of pessaries becoming embedded in the genital tract. Several years ago such a condition was observed in a cadaver in the dissecting room of the Medical College of Virginia. I have seen it become necessary to remove under anesthesia, and with a Gigli saw, an impacted doughnut-shaped pessary. Instances of fistula formation from pessaries have been recorded.

The explanation for the presence of the foreign body is not always clear. It must be that in most cases the object is placed in the vagina by the patient herself, though she frequently denies this. Often the denial is probably a wilful lie. Occasionally, perhaps, a child forgets what she has done, just as her mother forgets a menstrual tampon. In some cases the insertion of the foreign body is an act of masturbation; in others it may be due simply to a child's exploratory spirit. One child had previously put foreign bodies into her ears and nose. In one reported case an insane mother placed the object in the child. Some of the patients have been mentally deficient. In one case it was alleged that a brother, aged six years, had placed the multiple objects found in his two and a half year old sister's vagina. A child, aged nine years, in whom a button was found, said a boy classmate had "played with her privates" and she thought at one time had put something in her vagina. In the case of the tin box noted above, the foreign body was said to have been forcibly inserted by someone who ravished the girl. The paddy grain, previously referred to, had been worked into the vagina of a nine months old infant when she crawled onto a heap of paddy grain. The bael fruit had been inserted by the patient. It was her own method of treating a prolapsed uterus and the bleeding from an associated "epitheliomatous" lesion of the vulva. In two instances cotton from swabs was lost in the vagina by doctors taking smears. If I remember the legends correctly, and I may not, the Irish potato and the ligamentum nuchae of the ox, the museum specimens at Harvard, had been inserted by irate husbands.

It becomes necessary occasionally to use such foreign bodies as vaginal packs and tampons therapeutically in the vagina. Without medication these become very foul and should be rarely left in over twenty-four hours. We have found that by adding sulfonamide powder or solution, and more recently zinc peroxide in addition, packs can be left in several days, if necessary, with much less discharge and odor than formerly. We have routinely used

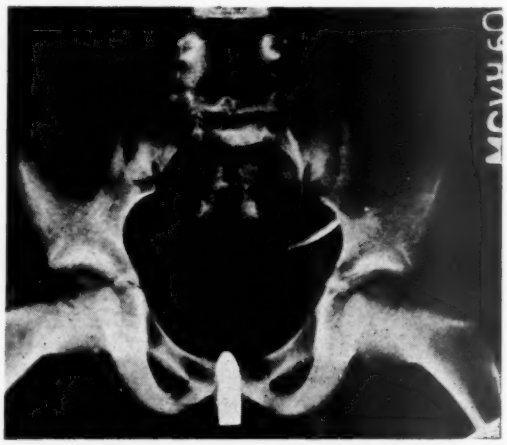

Fig. 3.—X-ray in Case 3, showing metal pencil top in vagina

such medicated packs in connection with radium therapy for carcinoma of the cervix.

Leucorrhea is the outstanding symptom of a vaginal foreign body. Often the discharge is bloody.

A sanguineous discharge in a child is almost pathognomonic of a foreign body. It goes without saying that all patients with leucorrhea or abnormal vaginal bleeding should be examined. In the case of a child, a rectal examination should be done. Then, usually the foreign body can be palpated through the anterior rectal wall. The rectal finger will serve as a guide for introducing a probe or hemostat into the vagina. In most cases when the instrument strikes the foreign body a characteristic sensation is elicited. Metallic bodies may be detected by x-ray, though this method of detection is rarely necessary. The object can be grasped with a hemostat or similar instrument under the guidance of the rectal finger, and removed usually without difficulty. In the case of sharp objects, care must be taken not to penetrate the tissues. The use of a urethroscope in the vagina in children may sometimes be helpful. Anesthesia is rarely necessary. Usually the signs and symptoms quickly subside following removal of the foreign body.

The majority of cases of vaginal foreign bodies are in children. During a period of four months in 1944, five cases of foreign vaginal bodies in children were seen by Dr. T. S. Chalkley and the departments of pediatrics and gynecology at the Medical College of Virginia. These are as follows:

CASE 1. A 4½ year old white girl had had a bloody vaginal discharge for one month. A smear showed many mixed organisms including gram-positive extracellular diplococci. A toy clothes-pin was removed on May 15, 1944.

CASE 2. A 2 year old white girl had had a foul discharge for one month. A diaper clip was removed on July 28, 1944.

CASE 3. A 7 year old white girl had had enuresis for years, worse for the past few weeks. Blood was noted in the voided urine. Masturbation had been observed. Vaginal smears were reported positive for the gonococci. Recently polypoid tissue had developed in the vestibule. A metal pencil top was removed on July 31, 1944. This patient had been cystoscoped because of the bloody urine.

CASE 4. A 4 year old white girl had had a yellow foul sometimes bloody vaginal discharge for two months. A closed safety pin was removed on August 17, 1944.

CASE 5. A 13 year old mentally deficient white girl had inserted a hairpin into the vagina two days previously. The patient's attempt to remove the hairpin caused penetration of the vaginal wall and bleeding. The foreign body was removed on September 14, 1944. Three years previously a bobby pin had been removed from the vagina of this patient.

A sixth case is that of a 4 year old colored girl who was brought to the St. Philip Hospital emergency room on May 8, 1945, with a hairpin partly projecting from the vagina. One prong, projecting outward, had perforated the tissues of the hymen, thus fastening the pin in the vagina. The pin was removed by cutting off a portion of the perforating prong and straightening and then withdrawing the remainder of the pin.

SUMMARY: The literature on foreign bodies in the vagina has been reviewed. Several additional cases are presented. These include six cases of foreign bodies found in children.

"Who is't can read a woman?"

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Physician Says Tongue Still a Good Indicator of Disease.

Years ago a doctor's observation and study of a patient's tongue were an important part of nearly every physical examination.

"Let me see your tongue," the old-time physician would ask his patient, and from its appearance and color he could usually make an accurate diagnosis. He was quick to recognize the strawberry tongue of scarlet fever, the shriveled tongue of dysentery and the brown, dry tongue of typhoid fever.

"Newer diagnostic methods and increased laboratory facilities have supplanted to some extent such detailed observation," says Russell A. Sage, M.D., of Indianapolis, but he adds that despite all the scientific advancements the modern physician can still rely on the tongue as an important indicator of many diseases.

Writing in the current issue of the *Archives of Otolaryngology*, published by the American Medical Association, Dr. Sage tells how nature has adapted the tongues of animals to meet individual requirements.

In man, sores of the tongue are commonly found on the surface or covering tissue which transmits sensations to the brain. Changes of temperature, touch sensations and the ability to perceive the four basic flavors—salt, sour, bitter and sweet—are the primary functions of the tongue-covering membrane.

"Generalized nervous disorders may be shown by certain misbehaviors of the tongue," Dr. Sage says, citing as examples the tremors seen in hyperthyroidism, the clumsiness of the tongue in decreased thyroid function and its "purposeless movements" in chorea or St. Vitus's dance.

In anemia, where the number of red blood cells or the amount of hemoglobin in the blood is reduced below normal, the tongue becomes pale.

A slick tongue, Dr. Sage says, usually means vitamin deficiency.

A coated tongue often has little to do with the state of a person's digestive system. "It may be a local condition due to lack of oral cleanliness," the author writes.

Edema or swelling of the tongue is due to infection or allergy. It often occurs in persons who have eaten fish, walnuts or chocolate, and it may result from bites and stings of insects or other injury.

An inflamed tongue might be caused by irritation from a jagged tooth or by an infection of the taste buds, while a burning tongue is usually associated with various forms of anemia and vitamin deficiencies. A poor fitting denture or excessive smoking may also cause a burning sensation of the tongue.

Vitamin deficiencies, due to lack of riboflavin and to lack of nicotinic acid (the cause of pellagra), bring on an inflammation of the tongue.

A "geographic tongue," in which the surface is marked by long, deep furrows instead of being smooth, is a common condition. Grayish thickened patches on the surface are noticed. The condition is "relatively harmless, but causes a great deal of worry in the mind of the patient," Dr. Sage says.

Ulcers of the tongue occur from infection and chronic irritation, and one of the most distressing tongue afflictions is the common canker sore. There are several types, and it is believed that indigestion, infected tonsils, adenoids and uncleanliness of the mouth and teeth are contributing causes to this unpleasant and painful mouth condition.

FIVE CASES OF LATENT TRICHOPHYTON INFECTION ACTIVATED BY THE USE OF PENICILLIN

ALBERT G. SCHNURMAN, M.D.,
Roanoke, Virginia.

The fundamental biologic and biochemical kinship of the various lower fungi has been repeatedly demonstrated.

In the five cases presented below, it is believed that with the original trichophyton infection an allergic state is produced; and that later, when penicillin is administered, an activation of the trichophyton allergic state occurs, resulting in complete manifestations of the original fungous disease.

Case I: H. F. O., male, age 24. Trichophyton infection of the feet in May, 1945. Proved by microscopic and cultural studies. Apparently cured by the use of salicylic acid ointment and potassium permanganate soaks, together with the use of ultraviolet light. In July, 1945, after a course of 300,000 u. penicillin I. M. for acute gonorrheal urethritis, the foot infection flared up and necessitated a repetition of the original treatment for trichophyton.

Case II: J. T. S., male, age 57, a baseball player. Treated and apparently cured of trichophyton infection with the above measures in January, 1945. In October, 1945, he was given a course of penicillin calcium tablets by mouth 1,500,000 u. for acute antral sinusitis. Two days later, his athlete's foot had recurred and required repetition of treatment.

Case III: O. H. B., female, age 46. Cured of athlete's foot for three years. Admitted to the hospital with an abscess of the upper jaw. Given 1,000,000 u. penicillin I. M. over a period of eight days. On the sixth day of administration, the patient complained of itching of the feet. Examination revealed an exacerbation of the old fungous infection.

Case IV: O. R. B., male, age 35. Had had "jock itch" while in the Army in the Pacific. Had been cured for a period of one year. Treated with 100,000 u. penicillin I. M. and 1,000,000 u. penicillin calcium simultaneously by mouth for acute gonorrheal urethritis. Thirty-six hours after the beginning of penicillin administration, treatment of a very acute "jock itch" condition was required.

Case V: A. G. S., male, age 34, with acute pharyngitis. Had had athlete's foot infection while in the Navy. Apparently cured for over 16 months. Took penicillin capsules 500,000 u. total and, during the administration, noted vesicular eruptions on the fingers and palms of hands from which nothing could be cultured, but from similar lesions on the feet, trichophyton was cultured with ease.

SUMMARY

Five cases are presented in which it is believed that penicillin has served to activate a latent trichophyton infection.

It is further believed that such activation is on an allergic basis because of biochemical allergenic similarity of the lower fungi.

501 Shenandoah Life Building.

XUM

THE FORUM

The First National Rural Health Conference.

In Chicago on March 30th, the first annual meeting of the National Conference on Rural Health was held. This meeting was sponsored by the Rural Health Committee of the American Medical Association. As representatives of your State Medical Society, Mr. Henry Johnson, the recently appointed Public Relations Officer, and I attended this session. Upwards of 180 individuals representing 40 of the 48 State Medical Societies, farm organizations, Government Agencies, etc., were present.

Dr. Crockett, Chairman of the AMA Committee on Rural Medical Service, presided and outlined the objectives of the gathering, which were primarily to discuss the problems relevant to the maintenance of rural health and the distribution of doctors in rural areas. The morning session was given up to prepared discussions on the various aspects of this problem.

Mr. Ranson E. Aldrich, Chairman, Medical Care Committee, Farm Bureau Federation, expressed the thought that as a fundamental proposition the various groups must work together. He stated that the farmer in general did not relish government subsidies. In his opinion, doctors charged too much for services to rural dwellers and that medical education cost too much in time and money.

Dr. Larson of North Dakota, representing the AMA Committee on Rural Medical Service, discussing the above paper, stated that doctors are likely to remain where their incomes are constant, that the problem was tied up with good roads and the relatively low economic status of the rural people. In any case, the practice of medicine must be made attractive to physicians. He also suggested that means of transportation be developed to bring the patients to the doctor, which would reduce the cost of medical care.

Dr. Mott of the Federal Security Agency cited figures to point up the need for medical care in rural areas, including the lack of Health Departments in 1,242 of the 3,070 counties in the United States. He suggested mandatory legislation to make communities match dollar for dollar to provide for health facilities. In further discussion of the problem, he stated that the rural purchasing power was low, and that the choices for a solution lay between:

1. Voluntary Health Insurance.
2. Compulsory Health Insurance.

In his opinion, the former would be inadequate and the latter would immediately solve all of the problems.

Dr. Victor Johnson, in an extemporaneous discussion of Dr. Mott's paper, emphasized that "evolution" was better than "revolution" in attacking this problem and that voluntary prepayment plans were quite young in point of time. Therefore, he felt that they had not been given a fair chance. Where tried, compulsory plans involved extensive red tape and invariably the overhead was more than predicted.

Mr. Strong, Secretary, Health Advisory Council of the Chamber of Commerce, emphasized the need for facilities in rural communities.

Mr. Leland Tate, formerly of V.P.I., temporarily with the Farm Foundation, gave an intelligent discussion of the importance of health education in rural communities to create an "awareness of health" and to overcome the present inertia. This must be conducted with regard to the educational status of the rural inhabitant, namely, on a common sense level.

Mrs. Sewell, of the American Farm Bureau Federation, gave a most intelligent and witty talk summing up the whole morning's work. She definitely favored a cooperative solution and not a government sponsored one.

Representative Priest, of Tennessee, gave the luncheon talk, which was quite general, but he spoke in favor of the Hill-Burton bill now in his committee.

The afternoon was given up to reports from the various states and it can be said that Virginia is well along, comparatively, in initiating various programs.

The AMA is definitely interested in attacking the problem at its source and hopes to stimulate state rural health committees to action.

May the writer appeal for your individual interest in this important fundamental problem. Frank discussions with your local people and farm organizations will serve to aid your Medical Society and

their Committee in an attempt to contribute to the betterment of medical care for rural people. Physicians must again be an integral part of their community, socially and economically, as well as medically.

H. B. MULHOLLAND, M.D.

Smallpox Treatment in 1717.

TO THE EDITOR:

Would the readers of the VIRGINIA MEDICAL MONTHLY be interested in the following from a letter of Lady Mary Montagu?

"Adrianople, Apr. 1 O. S. 1717.

"Apropos of distempers, I am going to tell you a thing that will make you wish yourself here. The smallpox, so fatal and so common amongst us, is here entirely harmless, by the invention of ingrafting, which is the term they give it. There is a set of old women who make their business to perform operations every autumn, in the month of September, when the heat is abated. People send to one another to know if any of their family has a mind to have the smallpox; they make parties for this purpose and when they are met (commonly 15 or 16 together), the old woman comes with a nutshell full of the matter of the best sort of smallpox, and asks which vein you please to have opened. She immediately rips open that you offer with a large needle (which gives no more pain than a common scratch), and puts into the vein as much matter as can lie on the head of her needle, and after that she binds up the little wound with a hollow bit of shell; and in this manner opens 4 or 5 veins * * * and are in perfect health to the eighth (day). Then the fever begins to seize them and they keep their beds 2 days, very seldom 3. They have very rarely about 20 or 30 in their faces, which never mark; and in eight days' time they are as well as before their illness * * * There is no example of anyone that has died in it; and you may believe I am very well satisfied of the safety of this experiment, since I intend to try it on my dear little son.

"I am patriot enough to take pains to bring this useful invention into fashion in England."

This above is an exact copy of Lady Mary's letter. I think she is somewhat confused in her Anatomy, for she probably does not mean "vein" where the old woman makes the scratch.

W. D. MACON, M. D.

Charlottesville, Virginia
December 15, 1945.

Editor's Note—The World's Best Classics, Vol. 4, Page 63 foot note reads, "Letter to Sarah Criswell, Dated Adrianople, Turkey, April 1, O. S., 1717. To Lady Mary is usually accorded chief credits for her introduction of inoculation into Western Europe."

Special Diet Relieves Fatigue Due to Sugar Deficiency in Blood.

Fatigue and dizziness from hypoglycemia, which is a deficiency of sugar in the blood, is effectively alleviated by dietary treatment with high proteins and complex carbohydrates.

Writing in the March 2 issue of *The Journal of the American Medical Association,* Major Samuel C. Karlan and Captain Clarence Cohn, of the Medical Corps, Army of the United States, say:

"Of 100 cases of fatigue and weakness studied, nine were believed to be primarily caused by hypoglycemia. The main complaints in all these cases were fatigue and dizziness. Unlike the fatigue in ordinary neurasthenia [psychoneurosis or nervous exhaustion characterized by abnormal fatigue], the fatigue suffered by these patients was not continuous but occurred at specified times, such as on arising in the morning or several hours after meals. It almost invariably occurred after having missed a meal. . . .

"The treatment used in these cases was entirely dietary. Diets high in proteins and carbohydrates of the more complex variety (starches rather than sugar) with frequent feedings prevented the symptoms in our cases."

XUM

PUBLIC HEALTH

I. C. RIGGIN, M.D.,
State Health Commissioner of Virginia.

The report of the Bureau of Communicable Diseases of the State Department of Health for April, 1946, as compared with the same month in 1945, and for the period of January through April, 1946, compared with the same period in 1945, follows:

	April 1946	April 1945	Jan.-April 1946	Jan.-April 1945
Typhoid and Paratyphoid	6	3	24	15
Diarrhea and Dysentery	152	118	560	930
Measles	2,598	273	6,988	903
Scarlet Fever	407	367	1,514	2,014
Diphtheria	27	23	168	103
Poliomyelitis	0	1	6	12
Meningitis	25	23	115	120
Undulant Fever	3	5	13	8
Rocky Mountain Spotted Fever	2	2	2	3
Tularemia	3	1	26	13

VIRGINIA'S MORTALITY RECORD IN WARTIME

In spite of the hardships of war due to crowded housing conditions, protracted working hours, and high tension living, the mortality experience on the home front was extraordinarily favorable. An average annual number of 28,713 persons died from all causes in Virginia during the war years, (1942-1944) with a rate of 10.2 per 1,000 population. This was the lowest rate on record for Virginia. During the prewar period (1939-1941) the average rate was 10.9. Both the white and colored races shared in the decrease.

The mortality experience of World War II shows some similarity, but a startling contrast as well, to World War I. The death rate of 14.0 in 1917 was a little lower than the rate (14.5) for the prewar year, 1916. However, in 1918, there was an abrupt rise and towering peak in mortality (rate 18.2) due to the influenza epidemic. It is noted also that the level of death rates during Warld War I was considerably higher than during the second world war.

Although there were potential health hazards due to the movement of the population to industrial areas and military training centers, mortality from communicable causes exhibited phenomenally low rates during wartime. The death rate for this group of diseases showed a decline of 20 per cent for the war period over the prewar years, 1939-1941.

The lowered rate for the respiratory diseases—tuberculosis, pneumonia and influenza—was especially noteworthy. The average annual rate of 50.4 per 100,000 population for tuberculosis during wartime represented a 15 per cent decrease over the prewar period (1939-1941). However, because of the long course of the disease, it is impossible at present to evaluate the true significance of the decline, as the full effect of wartime conditions on tuberculosis mortality may not be seen for some years.

The wartime death rate for pneumonia and influenza combined (70.2) was the lowest on record for the State.

Favorable health conditions in the State were influenced by the fact that no less than eight of the acute infectious diseases recorded lower death rates for the war period than for the last three prewar years. These causes comprised typhoid fever, diphtheria, whooping cough, measles, scarlet fever, tularemia, malaria and diarrhea-dysentery. Although deaths from epidemic meningitis, undulant fever, acute poliomyelitis, and Rocky Mountain spotted fever showed some gains during wartime, mortality from these diseases was not numerically great. The influence of the outbreaks of epidemic meningitis in 1943 and 1944, and of poliomyelitis in 1944 was noted in mortality from these causes.

Despite the increasing hazards of childbearing in wartime due to the participation of women in industry, maternal mortality registered a new low rate for the war period. The average annual rate of three deaths per 1,000 live births for the war years represented a 33 per cent decrease over the rate (4.5) for the prewar period, 1939-1941. As might be expected, the years of lowest maternal mortality showed the highest proportion of births attended by physicians and of deliveries occurring in hospitals.

The favorable mortality seen for maternal causes also maintained for infants under one year. The

average annual rate of 62.4 infant deaths per 1,000 live births during the period 1939-1941 fell to 50.1 during wartime.

The death rate of 76.9 per 100,000 population due to accidents occurring in the State during wartime showed a decrease of 7 per cent over the prewar years, 1939-1941. The reduction in accident fatality was brought about, for the most part, by a sharp decline in deaths due to motor vehicles.

Fatal occupational accidents, however, affected by a great increase in industrial activity, rose from 385 in 1941 to 538 in 1944, a gain of 40 per cent. The peak in mortality from industrial accidents occurred in 1943 when there were 586 deaths.

The decreasing death rates during wartime were a continuation of a significant downward trend during the past decade. With an increased effort toward lowering mortality from preventable causes, postwar death rates should continue downward, with a consequent lengthening life-span.

THE EMIC PROGRAM

COMMITTEE ON MATERNAL HEALTH
MEDICAL SOCIETY OF VIRGINIA

"When will the EMIC program end" has been asked so many times it may not be out of place that a few comments be made. These statements are being made without any attempt to praise or condemn the program.

The plan was begun in this State August 28, 1943. Many changes have occurred since that time but the main provisions have remained the same. The fund and the regulations are entirely federal; the administration, State. The fee for complete obstetric care is now $50.00. Smaller changes have been made in pediatric fees. Each hospital is paid on a basis of its cost per patient day. It is rare that the cost of any two hospitals is the same.

Up to May 1, 1946, a total of 24,691 patients have been authorized for care; of these 19,431 were obstetric and 5,260 were pediatric. The total cost has been $1,488,896.63. There has been approximately a 30 per cent decrease in the number of authorizations for the first four months of 1946 and the corresponding period of 1945.

The plan was set up to be continued until six months following the duration of the emergency. The end of the emergency has not been declared. If today were set as that time, and an obstetric patient were authorized for care at the end of the six months' period, she would receive care throughout pregnancy and the postpartum period; the baby, for twelve months thereafter. That means that the program could be continued for a minimum of twenty-seven months from the above date. Since it is always possible that a program of this type could be terminated *abruptly,* it is urged that physicians and hospitals submit bills as soon as services to these patients are complete.

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WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President—MRS. P. M. CHICHESTER, Abingdon
President-Elect—MRS. J. E. HAMNER, Petersburg
Recording Secretary—MRS. NATHAN SCHUMAN, Alexandria
Corresponding Secretary—MRS. L. C. BRAWNER, Richmond
Treasurer—MRS. REUBEN F. SIMMS, Richmond

Auxiliary to the Danville-Pittsylvania Academy of Medicine.

At a meeting on April 10, at which time the Auxiliary was reorganized, the following officers were elected: Mrs. Roy W. Upchurch, President; Mrs. Henry H. Hammer Vice-President; Mrs. Henry R. Bourne, Secretary; Mrs. Henry A. Wiseman, Treasurer; Mrs. Henry J. Langston, Chairman, Social Committee; and Mrs. Walter McMann, Chairman, Press and Publicity.

At this meeting it was decided to invite the President of the Auxiliary to the Medical Society of Virginia to the next meeting to aid in the reorganization and to give recommendations as to the best functioning of this organization.

Mrs. Chichester was present at the May meeting and gave a most interesting and instructive talk on the subject of the "Aims and Functions of the Woman's Auxiliary". It was decided that the project for the coming year be Cancer Control. Mrs. Roy W. Upchurch, President of the Auxiliary, is also President of the Cancer Control committee in Danville. The visit of Mrs. Chichester was most helpful and pleasurable to all members present. A luncheon preceded the address.

Soon after the reorganization, a tea was given for Mrs. Leota C. Swank, R. N., the new Superintendent of Nurses at Memorial Hospital, Danville.

Plans at present call for a monthly meeting during the year.

(MRS. WALTER) HELEN S. MCMANN,
Chairman, Press and Publicity.

Richmond Auxiliary.

The Auxiliary to the Richmond Academy of Medicine held its "Public Relations Day" meeting on April 19th at the Academy Building. An invitation had been issued to the representatives of all federated Women's Clubs and civic organizations of Richmond, and we were gratified by the number who were able to attend.

After a subscription luncheon, a brief report was given by the committees in charge of the annual bridge party to be held May 3rd for the benefit of Sheltering Army Hospital.

Mrs. E. L. Flanagan then introduced our speaker, Dr. I. C. Riggin, State Health Commissioner, who gave an informative talk on state and federal health legislation.

JULIA R. PASTORE (MRS. P. N.),
Acting Chairman, Press and Publicity.

The Mid-Tidewater Auxiliary

Has had a year of many difficulties, due to the extreme cold winter and illness in the families of its members.

Although we had expected to observe our regular Doctor's Day celebration at our April meeting in 1945, for several reasons we did not hold our regular meeting at this time.

Our July meeting was held in the hospitable home of Mrs. Arthur Van Name. At the business session it was moved and carried that each member raise at least $1.00 for our treasury. We then heard Dr. Charles Caravati who told some of his interesting experiences while in the Service and gave some helpful suggestions in the treatment of shell shock and other cases of returning veterans.

The October meeting was held with Mrs. Cox where we are always graciously received. The program on Cancer again urged us to "Fight Cancer with Knowledge" and stressed the fact that if taken in time cancer can be cured.

The January meeting also was with Mrs. Cox. The new officers for 1946 and 1947 were elected with Mrs. W. S. Cox as President and all other officers holding over for another year.

The Health Program suggested by the AMA was arranged.

The Mid-Tidewater Auxiliary looks forward to a year of progress under the capable and efficient leadership of Mrs. Cox.

ELLIE COCKE CAMPBELL (MRS. HAWES).

XUM

BOOK ANNOUNCEMENTS

Books received for review are promptly acknowledged in this column. In most cases reviews will be published shortly after the acknowledgment of receipt. However, we assume no obligation in return for the courtesy of those sending us same.

Cornell Conferences on Therapy. Edited by HARRY GOLD, M.D., Managing Editor; DAVID P. BARR, M.D.; McKEEN CATTELL, M.D.; EUGENE F. DuBOIS, M.D.; and CHARLES H. WHEELER, M.D. Volume One. New York. The Macmillan Company. 1946. xix-322 pages. Cloth. Price $3.25.

New and Nonofficial Remedies, 1945. Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1945. Issued under the Direction and Supervision of the Council on Pharmacy and Chemistry of the American Medical Association. 760 pages. Cloth.

There was a time, when the pharmacopoeia with its decennial revision was sufficient to keep one up to date on therapeutic remedies. That day has long since passed. New remedies are being introduced so rapidly that authoritative information is needed at more frequent intervals. One has only to mention hormones, both natural and synthetic, the sulfa drugs and penicillin to bring home the fact that an annual edition of *New and Nonofficial Remedies* is becoming more indispensable each year. The 1945 issue is well arranged and well indexed and its attractive format makes it a very handy reference book.

Convalescent Serum and Penicillin Best for Scarlet Fever.

A navy physician has found that simultaneous injections of human convalescent scarlet fever serum and penicillin provide the best means for treating scarlet fever.

Lieut. Comdr. Paul Ashley (MC), U.S.N.R., writing in the March 23 issue of *The Journal of the American Medical Association*, says that within 24 hours after the appearance of the rash the patients should have convalescent scarlet fever serum injected into their veins and 30,000 units of penicillin injected into the muscles. Thereafter, they should receive 15,000 units of penicillin every three hours until their temperature has remained normal for five days.

Comdr. Ashley states that the patients responded to this treatment better than to that of any other tried, regardless of the severity of the illness.

The blood serum comes from patients who are convalescent from scarlet fever and, when introduced into the body, it produces immunization by virtue of the antibodies which it contains. These antibodies are specific substances which react against an invading micro-organism.

Comdr. Ashley's report was based on 298 patients who were studied in groups of approximately 50 to compare different types of treatment.

The author says that from 50 to 60 per cent of the cases of scarlet fever observed were caused by certain types of group A beta-hemolytic streptococci which are resistant to the sulfonamides. Therefore, the author cautions against the use of sulfadiazine in the treatment of such patients.

Schering Gives $40,000 in Drugs to Red Cross for the Philippines.

Medical and surgical supplies were reported as one of the most critical needs for the desolated sections of the Philippines, following the recovery of the Islands by American troops. Government and relief agencies have since appealed for emergency supplies of these important materials.

Recognizing the urgency of the need, Mr. Francis C. Brown, president of Schering Corporation, recently authorized a gift of Schering drug products to the American National Red Cross for use by the Philippine National Red Cross in the civilian aspects of rehabilitation operations in the area. Valued at more than $40,000, this important contribution was promptly accepted by Mr. George C. Smith, general supply officer of the Red Cross in Washington. The shipment was made from the Schering plant in Bloomfield, New Jersey and convoyed under armed police guard to the *S. S. Rainbow* in Hoboken.

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EDITORIAL

Dr. J. Shelton Horsley

1870-1946

THE death of Dr. J. Shelton Horsley on April 7 brought an era to an end in Richmond and Virginia surgery. For the first time since the return of Dr. Hunter McGuire in 1865, Richmond is without a general surgeon in the older, broader sense of the term. While in more recent years Dr. Horsley was thought of primarily as an abdominal surgeon, his contributions in the fields of vascular, plastic, orthopedic, urological, neurological and gynecological surgery indicated a versatility that is no longer expected or found in the surgeon of today.

In a sense he was a product of his time. Although he spent two years postgraduate training in New York he was largely self-trained. The story of his introduction to surgery was typical of Dr. Horsley. While engaged in general practice in Staunton, shortly after his graduation from the University of Virginia in 1892, he was called to treat a man who had been run over by a train. He found it necessary to do a hip amputation and reported the case. Dr. John Allen Wyeth of New York, who devised the Wyeth pins for high thigh amputation, chanced to read this case report and wrote Dr. Horsley to congratulate him on the successful outcome. In the correspondence which followed Dr. Wyeth offered him an assistantship. Two years later, because of ill health, he went to El Paso, Texas, where he was Surgeon-in-Chief of the St. Luke's Hospital until his return to Virginia in 1903, as Professor of the Principles of Surgery at the Medical College of Virginia. The experimental dog house which he built during this period and operated for many years may be seen on 13th Street. Here medical students were introduced to the principles of surgery and experimental problems were begun which later stood the test of clinical application. In 1912 he opened St. Elizabeth's Hospital and fittingly named it after Mrs. Horsley, the former Miss Eliza Braxton of Staunton.

The originality and investigative spirit which characterized his earlier years at El Paso and the Medical College of Virginia continued unabated during the thirty-four years that he carried on his work at St. Elizabeth's Hospital. Here he developed the Horsley pyloroplasty and the Horsley modification of the Billroth I operation for gastric resection. While these two operations are probably most closely associated with his name, a review of surgical texts show no less than fourteen procedures or technical aids which were devised by him. Some of these operations have been superceded by more modern methods but it is a tribute to the physiologic principles upon which they were founded that none were discarded because they were basically unsound. Visiting surgeons always expressed surprise that Dr. Horsley's work was done in a small private hospital. This was particularly true of foreign visitors who associated clinical research only with large teaching hospitals.

Any movement designed to advance science received his wholehearted support. He was a founder and an early President of the Virginia Academy of Science. In 1925, as a memorial to his father, he gave $10,000, the interest of this sum to be awarded biannually for the most outstanding original work by a recent medical graduate of the University of Virginia. His interest in cancer increased with the years and culminated in his appointment in 1943 as the surgical representative on the National Advisory Cancer Council.

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Limitations of space prevent the enumeration of the many offices held by Dr. Horsley in local, state, regional and national medical societies. In 1926 he was elected President of the Medical Society of Virginia. He was a former President of the American Association for the Study of Neoplastic Diseases and for eleven years he was Chairman of the Council on Scientific Assembly of the American Medical Association. He was the recipient of many honorary awards. Shortly before his death he was elected a corresponding fellow of the Medical Society of London.

He was author of six books on surgical subjects and served as associate editor of the Lewis "Practice of Surgery" until his death. He wrote more than 250 articles on surgical topics. The vigor and clarity of his writings added much to the originality of the thought. The first few chapters of Volume I of "Operative Surgery", in which biologic and physiologic principles are discussed, are models of medical expression. As a speaker he was somewhat less effective but his ability to illustrate his subject by commonplace examples and the forcefulness of his delivery offset to a large degree any lack of fluency.

He was a man of strong convictions who spoke freely and frankly on any subject under discussion. He believed that words should reveal and not conceal the speaker's thoughts and his listeners were never left in doubt as to his stand on any question. He was intensely loyal to his friends. He aided the younger men who served under him with every means at his disposal and followed their later progress with interest and pride. It would be impossible to evaluate the extent of Dr. Horsley's influence but unquestionably it was great and many physicians and surgeons today have a higher regard for scientific truth and a keener interest in clinical investigation by reason of having been associated with him.

But in a larger sense, the doctors of Richmond and Virginia are all beneficiaries of Dr. Horsley, for he did much to raise the standard of surgery in Virginia and he helped to establish and maintain Richmond's position as a medical center.

HARRY J. WARTHEN, JR.

Calendars Old and New

EXCEPT at Easter and possibly when you are reading the history of the XVII and first half of the XVIII centuries, probably you never give the calendar a thought. The measurement of time is based on the motion of the heavenly bodies. A day represents one revolution of the earth on its axis. A month is one revolution of the moon around the earth. A year is the time it takes the earth to revolve about the sun. These units of time are made by God and cannot be changed. A calendar is an arrangement for keeping track of these units of time. It is man-made and can be changed. In fact, the calendar as we know it has been changed many times. The Sumerians had a lunar-solar calendar as early as 3500 B. C. The appearance of the new moon on the Western horizon was the signal to start a new month. Such a month was 29 days, 12 hours, and 44 minutes long, and twelve such months gave them a year of 354 days. Consequently, the Sumerians had to add an extra month about every third year to bring their calendar back in step with the seasons. The Jews inherited the Sumerian calendar. They had a fixed schedule for inserting the extra month. The Mohammedans, on the other hand, use a strictly lunar calendar and make no effort to bring it into conformity with the seasons.

About 500 B. C. the Chaldeans determined the length of the year to be 365 days, 6 hours, 15 minutes, and 41 seconds, which is less than half an hour wrong. Later

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on, about 300 B. C., the priests in Egypt made use of this value and introduced leap year, adding an extra day every fourth year.

The early Romans used a calendar similar to that of the Jews but had no rule for inserting the extra month. It was up to the authorities to insert the extra month whenever the calendar became a month fast. Politicians took advantage of this and often lengthened their term of office by this means. When Julius Caesar came into power the Roman calendar was so far wrong that the calendar indicated the beginning of Spring when it was really the beginning of Winter. He was impressed with the need for a scientifically constructed calendar. He called the astronomer, Sosigenes, to Rome from Alexandria, and the two designed the Julian calendar. The Julian calendar disregarded the phases of the moon entirely. The 365 days were divided into 12 months as follows: Januarius 31, Februarius 29, Martius 31, Aprilis 30, Maius 31, Junius 30, Quintilis 31, Sextilis 30, September 31, October 30, November 31, and December 30. Every 4th year an extra day was added to Februarius to take up the one-fourth day that was left over from the three previous years. To bring the calendar back into step with the seasons the year 46 B. C. was lengthened to 445 days, and the month Quintilis was changed to Julius in honor of the Emperor.

Caesar was assassinated a year after his calendar was put into operation, and through a misunderstanding leap year was inserted every third year. Augustus saw what was wrong and straightened out the difficulty, and while he was making the changes he changed the name of the seventh month to Augustus in honor of himself. Since the month named after Julius Caesar contained 31 days, Augustus increased the number of days in Augustus to 31, and to compensate for this he took a day from Februarius. This made three 31-day months come in a row, so he changed September to 30 days, October to 31, November to 30, and December to 31 days, respectively.

Sosigenes made a mistake of 11 minutes in the length of the year. This error amounts to one day every 128 years. After 1600 years the calendar was nearly two weeks wrong. According to the rule adopted at the Council of Nicea in 326 A. D., Easter was celebrated on the first Sunday following the first calendar full moon after the beginning of Spring. The date of March 21st was taken as the beginning of Spring. If Sosigenes' error had remained uncorrected, Easter would have come in time to be celebrated in Summer, then in Autumn, and finally in 29,000 years would have been celebrated in Winter. This was a serious matter and Pope Gregory XIII called together a commission to design a new calendar. The leap year rule was changed so that there would be 97 leap years in every 400 years, and to bring the calendar back into conformity with the seasons, ten days, October 5th to 14th, were dropped from the calendar for 1582. Catholic countries adopted the Gregorian calendar at once. England and the American colonies adopted it in 1752. By that time 11 days had to be dropped. This led to great confusion and some people thought that their lives were being shortened by almost two weeks, as indeed they were, for there were riots and bloodshed. Russia did not change her civil calendar until 1918, and the Greek Orthodox Church has never made the change.

New Year's day has been celebrated at various times by various peoples. The ancient Egyptians, Phoenecians, and Persians, began their year at the Autumnal equinox. The ancient Greeks started their year at the Winter solstice. The Jews begin their ecclesiastical year at the Spring equinox. The Romans for a hundred or more years before Caesar's time began their year in the Spring. That is the reason the last four months of our year bear names meaning the seventh, eighth, ninth, and tenth months. Caesar moved the first of the year to January 1st, and this was retained in

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the Gregorian calendar. The 25th of March was New Year's Day for most Christian peoples in the middle ages. This led to great confusion in dates between 1582 when the Catholic countries adopted the present calendar and 1752 when the English speaking countries adopted it.

The origin of the concept of the week is obscure. The ancient Scandinavians had a five day week. In some parts of Africa the week is only three days long. The seven day week originated in West Asia and from there spread to Europe and Africa. In most countries the week provides in a regular and systematic manner a market day and/or a day of rest. On the Congo the word for week is the same as the word for market. The second chapter of Genesis, second verse, states that on the seventh day God ceased his work, and that seems to be a good rule for human beings to follow.

The difficulty of fitting the week into the calendar is that 365¼ days more or less is not divisible by 7 or any other number, for that matter. Consequently, any given day in the calendar falls on a different week day from year to year. Christmas, for instance, came on Tuesday last year, and will come on Wednesday this year. I doubt if anyone knows on what day of the week Christ was born, not that it matters greatly, but when a certain day like Easter must fall on the same day of the week, it becomes necessary to have a calendar for that particular year at hand.

However, it is possible by setting the 365th day and the 366th day in leap years aside as days apart from any month, to construct a calendar in which each day falls on the same day of the week year after year. Nearly 100 years ago Auguste Comte suggested a calendar of 13 months. Each month would start on a Sunday and would consist of exactly four weeks. Each month would be exactly like every other month and each year would be like every other year. The 365th day was put at the end of the year after the last day of December and before the first day of January.

Many of the advantages of the Comte calendar can be had with less radical changes. The proposed World Calendar divides the 364 days into four equal quarters of 91 days each. The quarters contain exactly 13 weeks. Each month will contain the same number of working days. All the years will be the same so that a given date always comes on the same day of the week. Easter would always come on April 8th which is only one day away from the actual anniversary, April 9th. The 365th day, "Year End Day", follows December 30th. In leap years the extra day, another world holiday, follows June 30th which would be between a Saturday and a Sunday.

A similar calendar has been proposed by Lieutenant-Commander Willard E. Edwards of the U. S. Navy. In the Edwards calendar New Year's Day is the first day of the year and each quarter begins on a Monday. The second month of each quarter begins on Wednesdays and the third month of each quarter begins on Fridays. There are no Friday-the-thirteenths in the Edwards calendar. The 1st, 15th, and 30th, common payroll days, all fall on week days. The last business day of each quarter always falls on a Saturday. Each week begins on a Monday and Sunday becomes the seventh day of the week. With a fixed Easter there will be six 3-day U. S. A. holidays every year, and seven on leap years. Anniversaries and holidays will always fall on the same day of the week as well as the same day of the month. The year always ends on a Sunday which is very suitable for either Watch-Night services or New Year celebrations after the stroke of twelve at midnight.

Hawaii has given official recognition to the Edwards Calendar with the following resolution: Whereas, the perpetual calendar (also known as The Edwards Calendar) simplifies and revises the calendar scientifically and permanently with no more than two days' variation from the present system; now therefore Be It Resolved by the

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House of Representatives of the Twenty-Second Session of the Legislature of the Territory of Hawaii, that the Congress of the United States of America be and is hereby respectfully requested and urged to propose that The Edwards Perpetual Calendar be adopted by all nations at the Peace Conference and to propose to all United Nations that they now appoint a national committee to study The Edwards Perpetual Calendar with a view toward its acceptance at the Peace Conference.

PRESIDENT'S MESSAGE

TO THE MEDICAL PROFESSION OF VIRGINIA:

THE Cavalier Hotel Corporation has informed us that practically all of the Beach hotels are booked to capacity until November 1st; however, a definite number of reservations have been made for the members of the Medical Society of Virginia for the meeting in October. The hotel management would like to have these reservations made as soon as possible.

They have informed us that from ten to twenty-five reservations at every convention are not taken up and that the prospective guest failed to notify them in time for them to use the room, so that at least one day is a dead loss to the hotel. It was first thought that they would be justified in asking a deposit of twelve dollars for single rooms and twenty dollars for double rooms, in order to protect the hotel. However, they have stated that they will not require the deposit, provided the management is notified by wire or phone forty-eight hours before the expected arrival of a guest if he finds he will not be able to come. My own reaction to it is that if one is so negligent, the hotel would be justified in collecting for one day's occupancy.

The management of the Cavalier has undertaken to provide accommodations for guests who might not be located in the hotel in other hotels along the Beach front, so naturally, unless they receive cancellations, they would hold the Cavalier responsible for rooms not occupied.

I am sure it is only necessary to call your attention to this to see its fairness and to ask you to register early. Also, please cancel your reservation promptly if you find you will not be able to attend.

I look forward to seeing you at the Beach in October.

Yours very sincerely,

JULIAN L. RAWLS, *President,*
Medical Society of Virginia.

SOCIETIES

Virginia State Board of Medical Examiners.

At the meeting of the Board, March 25-28, the following applicants were granted licenses through examination:

Dr. Lane Ameen, Philadelphia, Pa.
Dr. Thomas A. Anderson, Jr., Houston, Texas.
Dr. Arthur Argoff, Harrisburg, Pa.
Dr. Lomas E. Ball, Abingdon.
Dr. William H. Barney, Roanoke.
Dr. Max Baumeister, Jr., Norfolk.
Dr. Frank M. Blanton, Richmond.
Dr. Joseph Alston Boyd, Jr., Atkinson, N. C.
Dr. Charles Harry Brant, Lakewood, Ohio.
Dr. James Webster Brooks, Winchester.
Dr. Esther Clark Brown, Salem.
Dr. Raymond Sidney Brown, Schley.
Dr. Royce Lee Brown, Norfolk.
Dr. Marvin Garten Burdette, Richmond.
Dr. David Staats Burnet, Orange, N. J.
Dr. Rowland Harvey Burns, Lebanon.
Dr. William Dimmock Buxton, Norfolk.
Dr. Edward Kent Carter, New Orleans, La.
Dr. Gilbert S. Campbell, Jr., Charlottesville.
Dr. John Cadwell W. Campbell, Richmond.
Dr. William Everett Carter, Alexandria.
Dr. William Byrnes Cecil, Dublin.
Dr. George Allan Chapman, Richmond.
Dr. Lewis Smith Chase, Hartford, Conn.
Dr. John Wallace Compton, Jr., Ronceverte, W. Va.
Dr. Edward Leslie Cole, Jr., University.
Dr. William Edward Copenhaver, Crockett.
Dr. George Edwin Cox, Memphis, Tenn.
Dr. Harry Duffield Cox, Charlottesville.
Dr. Geoffrey William Curwen, Worcester, Mass.
Dr. Dahar Cury, Jr., Norfolk.
Dr. James Hubert Davidson, Richmond.
Dr. Albert Henry Dudley, Jr., Baltimore, Md.
Dr. Arthur Ebbert, Jr., Wheeling, W. Va.
Dr. Walter L. Evans, Jr., Lynchburg.
Dr. Belle DeCormis Fears, Accomac.
Dr. Edward Graham Field, Nuttall.
Dr. Willard Milton Fitch, Parris Islands, S. C.
Dr. John R. Fitzgerald, Rochester, N. Y.
Dr. Ivan Graham Freed, Harrisonburg.
Dr. Don A. Gaddis, Arlington.
Dr. Robert Barrett Gahagan, Jackson Heights, N. Y.
Dr. Thomas Hancock Garth, Charlottesville.
Dr. John Alexander Gill, Richmond.
Dr. Sam Dixon Graham, Charlottesville.
Dr. Thomas Walton Green, Portsmouth.
Dr. Donald LeRoy Greever, Woodville, Ohio.
Dr. Clifton Rhodes Gruver, Pensacola, Fla.
Dr. Van Wyke Gunter, Richmond.
Dr. Owen Gwathmey, Richmond.
Dr. George Walter Hambrick, Jr., Princeton, W. Va.
Dr. George Southey Hankins, Newport News.
Dr. Gunyon Mitchell Harrison, Baltimore, Md.
Dr. Jacquelin M. Harrison, Charlottesville.
Dr. Robert William Hartley, Clifton Forge.
Dr. Wayland Jackson Hayes, Jr., Charlottesville.
Dr. Charles Wenger Hertzel, Denbigh.
Dr. Malcolmn Alexander Holliday, Charlottesville.
Dr. John Warren Hollowell, Portsmouth.
Dr. Mark Edgar Holt, Jr., Petersburg.
Dr. Grover Cleveland Honeycutt, Jr., Big Stone Gap.
Dr. Marcel Jerome Hornowski, Jamaica, N. Y.
Dr. Alice Swecker Huff, Norfolk.
Dr. Samuel Hammond Huff, Jr., Norfolk.
Dr. William Harvey Huffstetler, Jr., Richmond.
Dr. Richard Lemmon Hughes, Jr., Richmond.
Dr. Rupert Stanley Hughes, Jr., Richmond.
Dr. Malcolm Earle Hunter, Jr., Richmond.
Dr. George William Hurt, Roanoke.
Dr. James Byron Hutcheson, III, Roanoke.
Dr. Robert Price Irons, Charlottesville.
Dr. Clara Mae Iseley, Richmond.
Dr. Randolph Mott Jackson, Richmond.
Dr. Walter H. Johnson, Norfolk.
Dr. George Robert Jones, Richmond.
Dr. Homer Rodeheaver Justis, Lynchburg.
Dr. Elmore Porter Kalbaugh, Jr., Richmond.
Dr. Claude Kelso Kelly, Ayletts.
Dr. William E. Kelly, Brooklyn, N. Y.
Dr. Charles Kessler, Charlottesville.
Dr. Edward Joseph Kiember, Richmond.
Dr. Casper Sidney King, Boston, Mass.
Dr. John Talbert King, Burlington, N. C.
Dr. Howard Israel Kruger, Norfolk.
Dr. Matthew Lyle Lacy, II, Roanoke.
Dr. Morris Arthur Lambdin, Charlottesville.
Dr. Harry Teter Linger, Clarksburg, W. Va.
Dr. Charles Elroy Llewellyn, Jr., Richmond.
Dr. Richard Hubert Lowe, Jr., Roanoke.
Dr. John Milton Lukeman, Brooklyn, N. Y.
Dr. Theodore Roosevelt Mack, Richmond.
Dr. Joseph Hyman Marko, University.
Dr. John James Marra, Philadelphia, Pa.
Dr. Gerald Arthur Martin, Baltimore, Md.
Dr. James Dolan Mathias, Mathias, W. Va.
Dr. James Terrell May, Jr., Norfolk.
Dr. Lawence George May, Wind Gap, Pa.
Dr. Madge Dunn May, Norfolk.
Dr. Dennis Parfrement McCarty, Delaplane.
Dr. Walter Copley McLean, Charlottesville.
Dr. Charles Wesley Merritt, Boyle, Miss.
Dr. Henry Carl Messerschmidt, Jr., Richmond.
Dr. Unity Fern Monger, Harrisonburg.
Dr. Robert Patrick Moore, Hampden-Sydney.
Dr. Herbert N. Munhall, Jr., University.
Dr. Herman M. Nachman, Middleburg.
Dr. Richard Deaton Nauman, Richmond.
Dr. William Whitehurst Old, III, Norfolk.
Dr. Earl Tracy Owen, Lynchburg.

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Dr. Albert James Paine, Pittsburgh, Pa.
Dr. William Graham Painter, Big Stone Gap.
Dr. William Eugene Partee, Jr. (Col), Norfolk.
Dr. William Milholland Patterson, Charlottesville.
Dr. Samuel Randolph Penn, Roanoke.
Dr. Thomas Garland Potterfield, Wynnewood, Pa.
Dr. Lula Johnson Power, Charlottesville.
Dr. Robert L. Price, Norfolk.
Dr. Michael August Puzak, Arlington.
Dr. Richard Courtney Reed, Norfolk.
Dr. Emmett Francis Reese, III, Emory University, Ga.
Dr. Robert Legare Reeves, Madison, N. J.
Dr. Philip Gordon ReMine, Cleveland, Ohio.
Dr. Lewis George Richards, Jr., Oakland, Calif.
Dr. Benito B. Rish, New York City.
Dr. Charles Robinson, Richmond.
Dr. Maurice S. Rosenburg, Petersburg.
Dr. Milton Lewis Rosenburg, Charlottesville.
Dr. Charles Alfred Rothfuss, Williamsport, Pa.
Dr. Russell A. Salton, University.
Dr. Roy Burton Sampson, Jr., Roanoke.
Dr. Robert Hammond Sease, Raleigh, N. C.
Dr. Stuart McGuire Sessoms, Roseboro, N. C.
Dr. Herbert Ralph Silverman, Danville.
Dr. Thomas Emmett Smith, Hayes Store.
Dr. Robert Lee Sommerville, Richmond.
Dr. Catherine Hoover Stone, Richmond.
Dr. Raymond Edward Stone, Boston, Mass.
Dr. Paul S. Stonesifer, Jr., Roanoke.
Dr. William Hanna Talbot, Richmond.
Dr. Isabel Taliaferro, Richmond.
Dr. Thomas Murrell Thornhill, Jr., Lynchburg.
Dr. Oscar A. Thorup, Jr., Honolulu, Hawaii.
Dr. Andrew Martin Tiernan, Richlands.
Dr. Charles Newton Van Horn, Richmond.
Dr. Nancy King Wade, Washington, D. C.
Dr. George Richard Waterman, Union Springs, Ala.
Dr. Paul Paine Webb, Newcastle.
Dr. Stanley Wise White, Odd.
Dr. Robert Bocock Wilkins, Seattle, Wash.
Dr. Earl Edward Wilkinson, New Orleans, La.
Dr. Charles William Wilson, Seattle, Wash.
Dr. Morton Charles Wilson, Charlottesville.
Dr. Charlie F. Wingo, Richmond.
Dr. William Chisholm Winter, Jr., Chicago, Ill.
Dr. Fred Eugene Wise, Marmet, W. Va.
Dr. Sydnor Terry Withers, Norfolk.
Dr. George Andrew Zirkle, Jr., Chattanooga, Tenn.
Dr. John A. Cifala (Osteopath), Portland, Me.

LICENSED BY RECIPROCITY

Dr. Louis Edward Aaron, Raven.
Dr. Norman Adair, Charlottesville.
Dr. Arthur S. Bauer, Washington, D. C.
Dr. Jerome Nathaniel Baum, Merion, Pa.
Dr. Joseph Beinstein, Arlington.
Dr. Ernest Julius Benko, Norton.
Dr. Lester S. Blumenthal, Washington, D. C.
Dr. Robert Joseph Bosworth, Washington, D. C.
Dr. Randal A. Boyer, Richmond.
Dr. Lionel Abbit Canaan, Brooklyn, N. Y.
Dr. Earnest B. Carpenter, Newport News.
Dr. Walter Scott Clark, Arlington.
Dr. James Francis Clinton, Martinsville (Temporary License.)
Dr. Lilton C. Cobey, Washington, D. C.
Dr. Theodore R. Coleman, Front Royal.
Dr. Everett Roy Cooper, Marion.
Dr. Robert C. Crawford, Roanoke.
Dr. Benjamin Franklin Dean, Jr., Washington, D. C.
Dr. Stuart Jerome Eisenburg, Richmond.
Dr. Milton Flocks, Colonial Village.
Dr. Frederick V. Gammage, Bluefield, W. Va.
Dr. James A. Gannon, Jr., Arlington.
Dr. William T. Gill, Jr., Washington, D. C.
Dr. Jaye Grollman, Alexandria.
Dr. Clifford Folson Gryte, Franklin.
Dr. William Henry Hanna, Alexandria.
Dr. Jerome Blaine Harrell, Arlington.
Dr. Frederick C. Heath, Christiansburg.
Dr. Isaiah Allen Jackson, Jr. (Col.), Richmond.
Dr. Frank H. Jaklitsch, Fort Belvoir.
Dr. Naomi Kaplan, Arlington.
Dr. William Henry Kaufman, Charlottesville.
Dr. Roy George Klepser, Washington, D. C.
Dr. Henry Kulesher, Arlington.
Dr. Gardner H. Landers, Roanoke.
Dr. Jack Emanuel Lieppman, Richmond.
Dr. Arthur J. Linden, Arlington.
Dr. Harold R. Lipscomb, Tupper Lake, N. Y.
Dr. Thomas Lawman Lucas, Jr., Alexandria.
Dr. George Macatee, Jr., Fairfax.
Dr. Cameron Farquhar McRae, Jr., Lawrenceville.
Dr. Donald William Mitchell, Arlington.
Dr. Russell W. Moses, Washington, D. C.
Dr. Bernard Donald Packer, Madison, Wis.
Dr. Harry Pariser, Norfolk.
Dr. Nelson Podolnick, Fairfax.
Dr. John Taylor Ransone, New York City.
Dr. John Sturdivant Read, Brooklyn, N. Y.
Dr. Thomas J. Ready, Arlington.
Dr. Margaret Williams Reid (Col.), Suffolk.
Dr. James S. Reitman, Alexandria.
Dr. Robert Wolcott Ripley, New York City.
Dr. Isadore Rodis, Washington, D. C.
Dr. William Hamilton Rodgers, Richmond.
Dr. Alvin V. Rouzer, Arlington.
Dr. Robert Cornelius Rush, Washington, D. C.
Dr. Norman Philip Scala, Washington, D. C.
Dr. Jack Schumacher, Arlington.
Dr. Thomas Williamson Selden, Norfolk.
Dr. James Edward Shull, Lebanon.
Dr. William B. Sims, Washington, D. C.
Dr. William Stringfield Sloan, Petersburg.
Dr. James Reginald Smith (Col.), Lynchburg.
Dr. William Sorrell, Arlington.
Dr. Edward T. Spunt, Lynchburg.
Dr. W. Biven Suter, Washington, D. C.

Dr. Frederick D. Suttenfield, McLean.
Dr. William James Tobin, Washington, D. C.
Dr. James Wallace Todd, Norfolk.
Dr. James Albert Watson, Norfolk.
Dr. Andrew John Welebir, Arlington.
Dr. Emerson Williams, Arlington.
Dr. Rowland Francis Wilkinson, Washington, D. C.
Dr. Frank Louis Williman, Washington, D. C.
Dr. Mary Stuart Wilson, Keysville.
Dr. Samuel Ross Wilson, Jr. (Col.), Norfolk.
Dr. J. Derk Zylman, Arlington.

APPLICANTS WHOSE TEMPORARY LICENSES WERE MADE PERMANENT

Dr. Nelson LeRoy Barnett, Newport News.
Dr. Houston L. Bell, Roanoke.
Dr. Albert H. Bond, Pikeville, Ky.
Dr. Peter Diacoumis Comanduras, Arlington.
Dr. Joseph Cleveland Commander, Martinsville.
Dr. Joseph Jacob Dobkin, Arlington.
Dr. Ruth Paterson Dow, Staunton.
Dr. Louis Aaron Eigen, Arlington.
Dr. Joseph Johnson Eller, Marion.
Dr. Charles Todd Garcia, Cape Charles.
Dr. John Guido Graziani, Farmville.
Dr. Frances Anna Hellebrandt, Richmond.
Dr. Walter Tillou Henderson, Jr., Honaker.
Dr. Frederick Guy Holt, Grundy.
Dr. Alvin Jacob Kistler, Wytheville.
Dr. Robert Winding Lee, Arlington.
Dr. Lee B. Martin, Alexandria.
Dr. William Edward Moody, Scottsville.
Dr. Solomon Granville Moore, Harper's Ferry, W. Va.
Dr. George Osborne Nelson, Jr., Nitro, W. Va.
Dr. Albert Elwood Pagan, Arlington.
Dr. Sandor D. Papp, Alexandria.
Dr. David Pollack, Richmond.
Dr. Charles Preston Pope, Jr., Pulaski.
Dr. Dalbert Joseph Richard, Alexandria.
Dr. Clyde Llewllyn Saylor, Hopewell.
Dr. Helen Marjorie Jacobson Sloan, Richmond.
Dr. George Speck, Arlington.
Dr. Lloyd LeGrand Thompson, Richlands.
Dr. James L. Thomson, Norfolk.
Dr. William Taliaferro Thompson, Richmond.
Dr. Charles Edward Troland, Richmond.
Dr. Clinton Williams Trott, Wytheville.
Dr. Frederick Joseph Wertz, Washington, D. C.
Dr. Thomas Frasier Williams, Arlington.
Dr. James Spencer Wilkinson, Wake Forest, N. C.

The Southwestern Virginia Medical Society

Had an excellent meeting in Wytheville on May the 3rd, with an attendance of seventy-five members in addition to guests. A number of doctors were admitted to membership and delegates and alternates were named for the State meeting at Virginia Beach in October. There was only one change in the program as previously announced—Dr. Robert C. Crawford of Roanoke substituting for Dr. Edward Hanrahan of Baltimore, who unfortunately was ill. Dr. Crawford's subject was the "Rh Factor". Dr. A. P. Jones of Roanoke is president and Dr. A. F. Giesen of Radford secretary.

The Fall meeting will be held in Radford on the first Thursday in October.

Roanoke Academy of Medicine.

At the regular monthly meeting of the Academy on May the 6th, the following officers were elected to serve for the year beginning October 1946: President, Dr. Charles A. Young, and secretary-treasurer, Dr. Wade H. Saunders. Members of the Executive Committee are: Dr. A. M. Groseclose, Dr. Frank Farmer, Dr. Fred Hamlin, Dr. Charles W. Dorsey, and Dr. Chas. H. Peterson. The Judiciary Committee is composed of Dr. J. W. Preston, Dr. J. O. Boyd, Dr. W. R. Whitman, Dr. H. B. Stone, Sr., and Dr. W. W. S. Butler. All are of Roanoke.

The Fourth District and Southside Virginia Medical Association

Met on April 24th at the Raiford Memorial Hospital in Franklin under the presidency of Dr. W. D. Kendig, Kenbridge. The following program was presented: Medical Economics—A review of recent programs of the American Medical Association by Dr. Walter B. Martin, Norfolk; Chest Pain—A Differential Diagnosis by Dr. Clifford F. Gryte, Franklin; and Estrogenic Deficiencies as Affecting Eye, Ear, Nose and Throat Problems by Dr. Morgan B. Raiford, Franklin. Dr. C. E. Martin, Emporia, is secretary of this Association.

Lynchburg Academy of Medicine.

A dinner meeting of the Academy was held on April 8th, at which time Dr. Watt W. Eagle of Duke University Medical School was the speaker. His subject was "Some Problems in Otolaryngology of Interest to the General Practitioner".

The May meeting was held on the 6th and was addressed by Drs. William B. Porter and I. A. Bigger of the Medical College of Virginia. They spoke on the medical and surgical problems involved in congenital defects of the heart.

Dr. Edwin A. Harper is president of the Academy and Dr. H. W. Hollingsworth secretary.

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Virginia Peninsula Academy of Medicine.

At the meeting of the Academy on the 20th of May, Dr. Frank R. Lock, professor of obstetrics and gynecology at Bowman Gray Medical School, Winston-Salem, North Carolina, spoke on "Endometriosis". There was an attendance of sixty-seven.

The following officers were elected: President, Dr. Robert H. Wright, Jr., Phoebus, succeeding Dr. Harvey G. Bland of Newport News; vice-president, Dr. George G. Hankins, Newport News, succeeding Dr. Russell Buxton; and secretary-treasurer, Dr. Chester D. Bradley, Newport News (re-elected).

NEWS

Program for Medical Society of Virginia.

Notices were sent members early in May, asking those who wish to present papers at the Virginia Beach meeting to send titles and abstracts to the Society's office by the 15th of June. This is just a reminder as the Committee will prepare the program from titles on hand at that time.

One other suggestion is that those who expect to attend should make reservations promptly by writing The Cavalier Hotel, Virginia Beach, as the capacity of the hotel is limited and there are advantages in staying at the headquarters hotel. When space is not available at the Cavalier, the management will book guests at other hotels which are cooperating.

Veterans Loan Fund.

The Council of the Medical Society of Virginia, at its winter session, auhorized the setting aside of a fund of $10,000 to be used in loans to returning veterans for the purpose of post-graduate education or establishing themselves in practice.

This is to be administered by a committee appointed by the Council and any veterans interested should communicate with the executive secretary of the Society, at 1200 East Clay Street, Richmond 19.

Personnel Changes, State Department of Health.

APPOINTMENTS EFFECTIVE MAY 1:

Dr. V. A. Turner, previously Health Officer for Augusta County, has recently returned from medical service with the Army, and has been appointed Assistant Director of Local Health Services, with headquarters in the Southwest District Office in Abingdon.

Dr. Cameron F. McRae, recently released from medical service with the Army, has been appointed Health Officer of the Russell-Wise Health District.

Dr. Wm. Y. Garrett has been appointed Health Officer of the Norfolk-Princess Anne Health District.

Dr. Thomas Scarlett, formerly Health Officer of Augusta-Rockingham-Harrisonburg Health District, and recently returned from medical service in the Army, has been assigned Health Officer to the Fairfax County Health Department.

TRANSFERS:

Dr. P. M. Chichester, Assistant Director of Local Health Services, was on May 1 transferred from the Southwest District Office at Abingdon to the Central Office in Richmond.

Dr. Linwood Farley, Health Officer of the Russell-Wise Health District, was transferred to the Prince William-Stafford Health District, with headquarters at Manassas, effective May 1.

RESIGNATIONS:

Dr. S. D. Gardner has resigned as Assistant Director of Local Health Services, effective May 16.

Dr. J. McIvor Jackson, Health Officer of the Norfolk-Princess Anne Health District, resigned as Health Officer, effective May 1.

Dr. W. W. Griggs, Health Officer of the Page-Warren-Shenandoah Health District, resigned, effective May 13.

The Virginia Society of Ophthalmology and Otolaryngology

Held its annual meeting at Hotel Roanoke, Roanoke, on May the 4th, under the presidency of Dr. Meade Edmunds of Petersburg. The meeting was well attended and interesting. At the business session, Dr. Thomas Hughes of Richmond succeeded to the presidency and Dr. Fred Hamlin of Roanoke was named president-elect. Dr. Francis H. McGovern of Danville was re-elected secretary-treasurer. The 1947 meeting will be held in Norfolk in May, exact date to be announced later.

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Appointments by Governor Tuck.

Dr. I. C. Riggin, State Health Commissioner, and Dr. Julian L. Rawls, Norfolk, president of the Medical Society of Virginia, have been appointed by Governor Tuck as members of the Legislative Commission created by the last General Assembly, to study private organizations which solicit funds from the public for medical care. Previously appointed on this Commission from the Senate and House of Delegates are Senators J. D. Hagood and Lloyd C. Bird, and Delegates J. Maynard Magruder, Henry S. Johnson and John Warren Cooke. Mr. Johnson is the newly appointed Director of Public Relations and Medical Service for the Medical Society of Virgina.

Dr. H. B. Mulholland,

Charlottesville, who attended the First National Rural Health Conference in Chicago in March, was put on the A.M.A. Committee of Rural Medical Service by the Board of Trustees of the American Medical Association. He was also named chairman of the Mid-Atlantic and Southern section of the Rural Medical Service Conference, which comprises the states of Maryland, West Virginia, Tennessee, Kentucky, North and South Carolina and Virginia.

Dr. E. Lynwood Bagby,

Formerly of Richmond but who has been connected for the past year with the Clinch Valley Clinic Hospital at Richlands, located in Pearisburg, the middle of May, and is associated with Dr. W. C. Caudill.

McGuire Hospital,

Richmond, joined with other Veterans Administration hospitals in the observance of National Hospital Day on Sunday, May 12, and at an open house during the afternoon approximately 3,500 persons visited the 1,000-bed institution. The program included music by Sandy Martin's orchestra, and refreshments were served by the American Legion Auxiliary. Religious services were held during the morning. The Red Cross Gray Ladies served as escorts for the open house.

VA has designated McGuire a general medical and surgical hospital, but 200 beds have been alloted for the care of tuberculous veterans from the vicinity of Richmond. Specialized equipment for the care and treatment of veterans with spinal-cord injuries will be provided.

Married.

Dr. Carter Redd Rowe, Boston, Massachusetts, and Miss Mary Skinner Moore, Edenton, North Carolina, April 27th. Dr. Rowe practiced for several years in Fredericksburg before entering the Service. He is now located in Boston.

Dr. and Mrs. Andrew D. Parson of Richlands announce the marriage of their daughter, Alice Frances, to Robert E. Paine, Jr. of Roanoke, on May the 1st. Mrs. Paine is employed as a chemist with the Valentine Company in Richmond, and Mr. Paine is a member of the Senior class in medicine at the Medical College of Virginia.

Dr. Byrd Charles Willis,

Formerly engaged in practice in Richmond but for many years a prominent surgeon of Rocky Mount, N. C., has retired from active practice and is now making his home at Orange, this State.

Dr. Griffith Still Active at 85.

Dr. R. S. Griffith, beloved physician and citizen of Waynesboro, on April 16th celebrated his 85th birthday. He has practiced in the former Basic City and Waynesboro since 1891, and now numbers among his patients the fourth generation in two or more families in Waynesboro. He is also the possessor of four 50-year organization pins—as surgeon for the Chesapeake and Ohio and Norfolk and Western railroads, the 50-year Masonic pin, and another marking the 50th year of the local lodge of Odd Fellows in his city.

We wish Dr. Griffith many years of continued health and happiness!

Appointed to McGuire Veterans Administration Hospital.

Dr. E. M. Ellerson, acting manager, announces that four doctors and one dentist have been named recently to key positions at McGuire Veterans Administration Hospital.

Dr. Benedict Nagler, of Newark, N. J., diplomate of the American Board of Psychiatry and Neurology, has been appointed chief of neuropsychiatric service at McGuire, and Dr. Samuel Richman, of New York City, a member of the American College of Radiology, has been made chief of roentgenological service.

Dr. James B. Funkhouser, formerly of the staff of Southwestern State Hospital, Marion, Va., will serve as assistant to Dr. Nagler, while Dr. Joseph

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Krimsky, of Charlottesville, Va., who was an examiner at the Richmond Induction Station during World War II, will be assistant chief of eye, ear, nose and throat service.

Dr. Norval H. McDonald, of Baltimore, Md., chief of dental service at McGuire under Army operation, has been appointed to head the service under VA.

Dr. William Bickers,

Richmond, has returned after six months as acting professor of gynecology and obstetrics at the American University of Beirut, Lebanon. He served at the Near East College, assisting in restoring its operation to a pre-war basis. In addition to teaching, Dr. Bickers held clinics in Damascus, Tripoli, Tehran, and Bagdad.

Dr. B. B. Bagby, Jr.,

Formerly medical director at Pine Camp Hospital, Richmond, has been appointed director of the Negro division of Battey State Hospital, Rome, Georgia. He left Richmond in the fall to become tuberculosis director of the Georgia State Hospital at Milledgeville.

Dr. T. B. Pope

Has been appointed as coroner of the city of Petersburg to succeed Dr. Henry M. Snead who recently resigned. Dr. Pope has been associated with Dr. Snead since March 1st, having come to Petersburg from West Virginia where he had practiced for twelve years. He is a native of Southampton County and a graduate of the Medical College of Virginia in the class of '34.

Dr. Francis N. Taylor,

Recently returned to Petersburg after four years in Service, has been appointed by the City Council of that place as jail physician, also succeeding Dr. Snead, resigned.

American College of Physicians.

At the annual meeting of the College, held in Philadelphia May 13-17, Dr. David P. Barr, Cornell University, New York, was elected President to succeed Dr. Ernest E. Irons of Chicago. Other officers are Dr. Hugh J. Morgan, Nashville, Tennessee, President-Elect; Drs. James J. Waring, Denver, Colorado; A. B. Brower, Dayton, Ohio; and T. Homer Coffen, Portland, Oregon, Vice-Presidents. Mr. E. R. Loveland, Philadelphia, is Executive Secretary.

Home Again.

In addition to names previously published, we have been advised of the return from Service of the following members of the Medical Society of Virginia:

Dr. Charles M. Caravati, Richmond.
Dr. George B. Craddock, Lynchburg.
Dr. J. D. Creger, St. Paul.
Dr. Hal Davis, Roanoke.
Dr. William M. Deyerle, Richmond.
Dr. Jerome Feldman, Richmond.
Dr. Glenn T. Foust, Jr., Norton.
Dr. John E. Gardner, Roanoke.
Dr. J. R. Grinels, Richmond.
Dr. W. G. Hardy, Bedford.
Dr. O. H. McClung, Jr., Lexington.
Dr. Milton Salasky, Norfolk.
Dr. W. A. Seawell, Raven.
Dr. V. A. Turner, Abingdon (formerly Staunton).

New Director at Richmond V.D. Hospital.

Assistant Surgeon Allen D. Miller, U. S. Public Health Service, has been named medical director of the Richmond Municipal Hospital for Treatment of Venereal Diseases, succeeding Dr. E. R. Mautner who has been transferred to Baltimore.

Dr. James Q. Gant,

Class of '35, Medical College of Virginia, and for several years connected with some government service, has located for private practice, with offices at 1726 M Street, N. W., Washington, D. C.

The American Association for the Study of Goiter

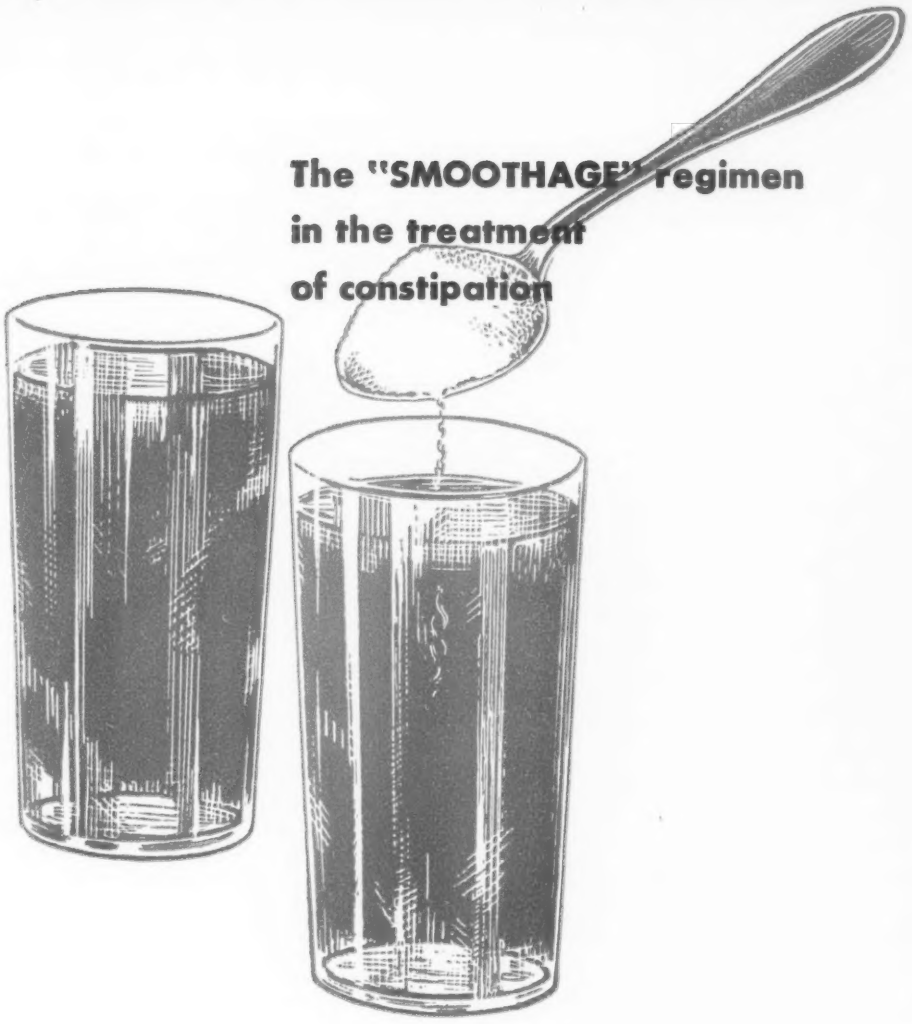
Is to hold its annual meeting at Drake Hotel, Chicago, June 20, 21 and 22, under the presidency of Dr. J. deJ. Pemberton of Rochester, Minn. Papers are to be presented at both morning and afternoon sessions on the first two days and dry clinics will be held until noon of the last day. There will be an informal cocktail party and banquet on the first evening. Dr. T. C. Davison of Atlanta, Ga., is corresponding secretary.

Veterans Administration, Richmond Branch Office.

Dr. Daniel B. MacCallum, formerly professor at the medical school of the University of Southern California, has been appointed director of medical services of the Richmond Branch Office, Veterans Administration, according to an announcement by James B. Cress, branch deputy administrator.

Medical operations in VA hospitals, homes and

The "SMOOTHAGE" regimen in the treatment of constipation



A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day, provides the soft, mucilaginous bulk which is desirable for natural elimination. Metamucil contains no roughage, no oils, no chemical irritants.

Metamucil is the highly purified, nonirritating extract of the seed of the psyllium, Plantago ovata (50%), combined with anhydrous dextrose (50%). It mixes readily with liquids, is palatable, easy to take.

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RESEARCH IN THE SERVICE OF MEDICINE

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offices throughout Virginia, North Carolina, West Virginia, Maryland, and the District of Columbia will be under Dr. MacCallum's direction. Dr. Wilbur R. Southward will continue as assistant director of medical services.

Commenting on the medical setup, the new director said that more and more doctors are entering VA's new department of Medicine and Surgery but that there are still a number of positions open for qualified men.

The most pressing need, he said, is for physicians to serve on rating boards, which pass on disability claims made by veterans. Each board is made up of a medical, a legal and an occupational member, but no difficulty has been experienced in filling the latter two positions. Physicians, however, are needed for both full and part time work on the boards if the increasing backlogs of veterans' disability claims are to be cleared up. While 18 physicians have been employed as full-time rating board specialists and two part-time, there are at least 20 more needed.

Dr. MacCallum pointed out that increase of the starting salary to $5,180, relaxing of minimum physical standards, and new working hours are among recent changes which should make the rating board positions particularly desirable for older doctors wishing to withdraw from full-time private practice or for those who want to devote only a part of their time to service on the board. Doctors may now serve only a few hours a week on a part-time basis if they desire.

In addition to the rating board vacancies, the new director said there are openings for approximately 170 doctors in hospitals and out-patient clinics in the branch area. Around 40 doctors have been employed full time and 13 part-time since the last of March.

2,000 to Attend College of Surgeons' Assembly.

More than 2,000 surgeons and other doctors of medicine are expected to attend the three-day Assembly of the United States Chapter, International College of Surgeons in Detroit, October 21-22-23.

Among the principal speakers to be heard in Detroit's Masonic Temple will be Mr. Hamilton Bailey of London, England; Dr. Francisco Granã of Peru; Dr. Felipe F. Carranza of Argentina; Dr. Manuel Manzanilla of Mexico; Dr. Wayne W. Babcock of Philadelphia, and many other leading surgeons of the United States.

Dr. Herbert Acuff of Knoxville, Tennessee, is President and Dr. Custis Lee Hall of Washington, D. C., is President-Elect of the U. S. Chapter, International College of Surgeons. Detailed information and copy of the Program may be obtained by writing L. J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan.

Raiford Memorial Hospital Clinics.

The third annual meeting of the summer clinics of this Hospital will be held in Franklin on June 19th, July 24th, and August 28th. The topic for the June meeting will be Problems in Obstetrics and Gynecology, and for July Gastro-Intestinal Diseases.

Lynchburg Tumor Clinic.

The Virginia Cancer Foundation announces the opening of the Lynchburg Tumor Clinic—the ninth of these clinics to be certificated by the Cancer Committee of the Medical Society of Virginia. Medically indigent cancer patients referred to this clinic in the usual manner will be cared for financially by the Foundation. Dr. Joseph Houck and Dr. John W. Devine are co-directors and the Out-Patient Clinic is in the Lynchburg General Hospital.

Dr. George H. Kinser,

Formerly of Waynesboro, has been transferred to Orange, Texas, where he will be with the medical department of the nylon salts plant of E. I. Du Pont.

Dr. Charles W. Scott

Has been appointed as superintendent of Piedmont Sanatorium at Burkeville to succeed Dr. J. B. Woodson who recently resigned. He has been medical director of the institution since 1942.

New Books.

The following are new books recently acquired by the Library of the Medical College of Virginia and are available to our readers under usual library rules:

Armstrong—Bone-grafting in the treatment of fractures.
Bauer—Constitution and disease, applied constitutional pathology. 2nd ed. 1945.
Bowman—Marriage for moderns.
Brain—Diseases of the nervous system. 2nd ed. 1940.
Brookes—Poisons; their chemical identification and emergency treatments.
Burch & Winsor—Primer of electrocardiography.
Burket—Oral medicine. Diagnosis—Treatment.

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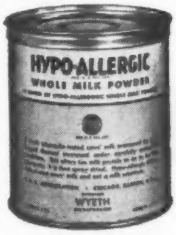

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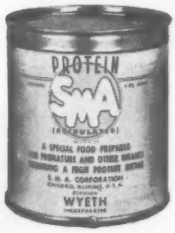

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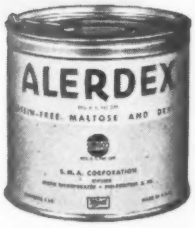

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Byrd, comp.—Health instruction yearbook. 1945.
Caffey—Pediatrics X-Ray diagnosis.
Cameron—Recent advances in endocrinology. 5th ed. 1945.
Curtis—Textbook of gynecology. 4th ed. 1944.
Dorcus & Shaffer—Textbook of abnormal psychology. 1945.
Fritsch—The structure and reproduction of the algae. v. 2.
Golden—Radiologic examination of the small intestine.
Groff & Houtz—Manual of diagnosis and management of peripheral nerve injuries.
Gumpert—You are younger than you think.
Howell—A textbook of physiology. 5th ed. 1946.
Kirschenbauer—Fats and oils. 1944.
Lange—Handbook of chemistry. 5th ed.
Levine—Clinical heart disease. 3rd ed. rev. 1945.
Lewis & Pasella—Modern trends in child psychiatry.
McCarrison—Studies in deficiency disease.
Millard & King—Human anatomy and physiology. 2nd ed. 1945.
Rahn—Microbes of merit. 1945.
Richardson—Patients have families.
Salle—Fundamental principles of bacteriology.
Sante—Principles of roentgenologic interpretation.
Thorek—The face in health and disease. 1946.
Williams—Leave her to heaven (Novel).
Wiprud—The business side of medical practice.
Wolf—The physician's business, practical and economic aspects of medicine. 2nd ed. 1945.
Wood—Medicology, or home encyclopedia of health.
Wrench—The wheel of health.
Yearbook of dermatology and syphilology. 1945.
Yearbook of general therapeutics. 1945.

Established Hospital for Lease.

A Sanatorium for nervous, mental, alcoholic and drug cases, doing an excellent business, to a reputable physician or medical group. Dr. E. W. Stokes, 923 Cherokee Road, Louisville 4, Ky. (*Adv.*)

For Sale—

General practitioner's office equipment, including the following practically new items: Cambridge Portable Electrocardiograph and Table; Jones Metabolor; Burdick Ultra Violet Lamp. Address "Equipment", care this journal, 1200 East Clay Street, Richmond 19. (*Adv.*)

Appointments Available.

An appointment in Eye, Ear, Nose and Throat is available October 1st at the Raiford Clinic, Franklin.

Also available immediately is an appointment in pediatrics.

For further details, address the Administrator, Raiford Memorial Hospital, Franklin, Va. (*Adv.*)

Wanted—

Technician for private practice and internal medicine in Newport News, Va. Address "XYZ", care this journal, 1200 East Clay Street, Richmond 19. (*Adv.*)

OBITUARIES

Dr. Spencer Glas Gill,

Norfolk, died May 17th, at the age of fifty-eight. He graduated from the Jefferson Medical College, Philadelphia, in 1914 and had practiced in Norfolk for twenty-eight years. Dr. Gill had been a member of the Medical Society of Virginia since 1917.

Dr. John Morgan Biedler,

For many years a practicing physician in Harrisonburg, but for the past year and a half of Fort Lauderdale, Florida, died January the 26th, at the age of seventy-two. He was a native of this State and graduated in medicine from the former University College of Medicine, Richmond, in 1903. He saw service in the army during World War I, was for many years health officer and coroner of Rockingham County, and one of the founders of the Rockingham Memorial Hospital at Harrisonburg. He had been a member of the Medical Society of Virginia since starting to practice.

Dr. Stephen Roszel Donohoe,

Formerly of Norfolk, died at the Veterans Administration Hospital in Washington, D. C., March 13, after a long illness. He was sixty-six years of age, and a graduate in medicine from the University of Maryland in 1902. He had been a member of the Medical Society of Virginia for over twenty-five years.

Dr. Hunter McGuire Williams,

North Garden, died May 14th of a heart attack. He was sixty-seven years of age and a graduate of the former University College of Medicine, Richmond, in 1900. Dr. Williams was formerly a member of the Medical Society of Virginia. A daughter and a son, Dr. John Stuart Williams, of Hopewell, survive him.